

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10777

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>718 Somerset Pl. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Alfred Southwood Adams</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant owner</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural & Subarachnoid Hemorrhage</u> DUE TO <u>Fracture of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>Fracture of skull</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down outside steps at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10:45</u> o. m. <u>p.m.</u> <u>10-12</u> 1957		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Washington, D.C.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschalt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschalt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>10/13/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Atlantic City Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pleasantville, N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. H. Hines</u>		ADDRESS <u>2901-14 St. N.W.</u>	
DATE <u>10-15-57</u>		24a. REC'D BY REGISTRAR <u>J. Wilson Saddy</u>	
		24b. REGISTRAR'S SIGNATURE	

RE: 94001148-KYARK 90 WYOMING STATE CHARTER

BUREAU V. S.

OCT 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 18 Film 222 11-1-57 ans
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10578216

10810

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		MARYLAND c. LENGTH OF STAY IN 1b 13 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 1736 Kenyon Street, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Neelam Middle (None) Last Ajmani		4. DATE OF DEATH Month October Day 19, Year 1957			
5. SEX Female	6. COLOR OR RACE Brown	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1951		9. AGE (In years last birthday) 6 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) India	
13. FATHER'S NAME Chandar Ajmani		14. MOTHER'S MAIDEN NAME Savitri Devi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 467.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prolonged irreversible hypotension DUE TO (c) Post-op. state, closure VSD 24 hr.					INTERVAL BETWEEN ONSET AND DEATH 24 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 6, 1957 , to October 19, 1957 , that I last saw the deceased alive on October 19, 1957 , and that death occurred at 2:10p M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Robert T. L. Long		M.D. The Clinical Center		DATE SIGNED 10/20/57	
PHYSICIAN'S NAME (Type) ROBERT T. L. LONG, M. D.		ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal Oct. 21, 1957		22b. DATE THEREOF Oct. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Lees Crematory	
22d. LOCATION (City, town, or county) Wash. D. C.		22e. (State) D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees		ADDRESS Lees - Wash. D. C.		24a. REC'D BY REGISTRAR 001 221957	
24b. REGISTRAR'S SIGNATURE Bessie Thompson					

BUREAU V. 5

70CT 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10811

CERTIFICATE OF DEATH

10779

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN lb <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co. General Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>19 57</u>	
3. NAME OF DECEASED (Type or print) First <u>Tobias</u> Middle <u>Railly</u> Last <u>Alcorn</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/10/80</u> 9. AGE (In years last birthday) <u>77 yrs.</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Alcorn</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hopkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Record</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia-right lung</u> DUE TO <u>177x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Liver</u> (c) <u>Carcinoma Prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma prostate - metastasis to liver</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/9</u> , 19 <u>57</u> , to <u>10/10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/10/57</u> , 19 <u>57</u> , and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>J. W. Bird</u> M.D.		DATE SIGNED <u>Sandy Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u>		DATE SIGNED <u>Sandy Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sandy Spring</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>CT 15 1957</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Snowden</u>	

OCT 15 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10812

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 63 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Chester Robert ANDERSON				4. DATE OF DEATH Month Day Year October 23 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 July 1910	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Commercial (Restaurant) District of Columbia			
11. BIRTHPLACE (State or foreign country) U.S.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Robert ANDERSON				14. MOTHER'S MAIDEN NAME Lucy TOLSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1-22-42 to 10-17-45				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Address (Wife) Mrs. Estelle M. Anderson (Same As #2)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection and Chronic Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma of the stomach DUE TO (c) Adenocarcinoma of the stomach							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 20 August , 19 57 , to 23 October , 19 57 , that I last saw the deceased alive on 22 October , 19 57 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 10-23-57							
ACTUAL SIGNATURE Robert P. Dobbie, Jr.				M.D. U.S. Naval Hospital, Bethesda, Md. 10-23-57			
PHYSICIAN'S NAME (Type) Robert P. Dobbie, Jr. CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md. 10-23-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-28-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Jarvis, 1432 "U" St., N.W. Washington, D.C.				24a. REC'D BY REGISTRAR 10-23-57 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		SEX MALE	
DATE OF DEATH OCTOBER 25, 1957		AGE 67 YEARS	
NAME OF DECEASED JAMES EARL RAY		RACE WHITE	
ADDRESS 1001 CONGRESS AVE BALTIMORE, MD 21201		OCCUPATION AUTHOR	
DATE OF BIRTH OCTOBER 10, 1910		PLACE OF BIRTH MOBILE, ALA	
CAUSE OF DEATH (To be filled in by physician)		MANNER OF DEATH (To be filled in by physician)	
SIGNATURE OF PHYSICIAN (To be filled in by physician)		SIGNATURE OF REGISTRAR (To be filled in by registrar)	

BUREAU V. 5

OCT 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Montgomery MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Anderson				4. DATE OF DEATH Month October Day 21 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1857	
9. AGE (In years last birthday) 100 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm work				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas Anderson				14. MOTHER'S MAIDEN NAME Rose Butcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis with uremia 177x DUE TO Obstructive uropathy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of prostate with metastases DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 mos 1 yr yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov , 19 56 , to 10/21 , 19 57 , that I last saw the deceased alive on 10/21 , 19 57 , and that death occurred at 4:00 p. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. H. Ligon				DATE SIGNED 10/21/57			
PHYSICIAN'S NAME (Type) C. H. Ligon				ADDRESS Sandy Spring Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/57		22c. NAME OF CEMETERY OR CREMATORY Hopkins Chapel		22d. LOCATION (City, town, or county) (State) Highland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swarden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR 25/1957	
				24b. REGISTRAR'S SIGNATURE Gertrude Lawley			

OCT 25 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10783 14
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>16 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10545 Sweetbriar Parkway</u>				d. STREET ADDRESS <u>10545 Sweetbriar Pky</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Lawrence</u> Last <u>Andresen</u>				4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>19</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-9-85</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>91 S. Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Friz Andresen</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Ester Andresen</u>		Address <u>Stm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous attacks</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10-30-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>				ADDRESS <u>4812 24 Ave NW Wash DC</u>		24a. REC'D BY REGISTRAR <u>NOV 4 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Frances Patter</u>				DATE <u> </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
NOV 4 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10783

10779

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY in 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 714 Erie Ave.				d. STREET ADDRESS 714 Erie Ave			
3. NAME OF DECEASED (Type or print) Samuel Edward Applegate First Middle Last				4. DATE OF DEATH Oct. 28/ 1957 Month Day Year			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/57		9. AGE (in years last birthday) 29 yrs.	IF UNDER 1 YEAR Months 29	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Randolph N Applegate				14. MOTHER'S MAIDEN NAME Hazel Breedon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 475X DUE TO Upper Respiratory Infection Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Found dead in bed	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		10/28/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Walters				ADDRESS 254 Carroll St. NW. D.C.		24a. REC'D BY REGISTRAR DATE 10/29/57	
				24b. REGISTRAR'S SIGNATURE John H. Walters			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10815

CERTIFICATE OF DEATH

10784

Reg. Dist. No. 226

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4707 Chevy Chase Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Caryl Middle Anne Last Aronson				4. DATE OF DEATH Month October Day 10 , Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1934	
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY Teaching		11. BIRTHPLACE (State or foreign country) Egypt	
12. CITIZEN OF WHAT COUNTRY? England ✓							
13. FATHER'S NAME Eric Harris				14. MOTHER'S MAIDEN NAME Mary J. Boyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior fossa intracranial tumor DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis of Both lungs DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 9, 1957 , to October 10, 1957 , that I last saw the deceased alive on October 10, 1957 , and that death occurred at 10:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/10/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Glenn A. Drager M.D.				PHYSICIAN'S NAME (Type) Glenn A. Drager, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 10-12-57		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Franklin County, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 10-11-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. HARRIS		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1910		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		MARRIAGE Married		MARRIAGE Married		MARRIAGE Married		MARRIAGE Married		MARRIAGE Married	
OCCUPATION Clerk		OCCUPATION Clerk		OCCUPATION Clerk		OCCUPATION Clerk		OCCUPATION Clerk		OCCUPATION Clerk	
EDUCATION High School		EDUCATION High School		EDUCATION High School		EDUCATION High School		EDUCATION High School		EDUCATION High School	
RELIGION Catholic		RELIGION Catholic		RELIGION Catholic		RELIGION Catholic		RELIGION Catholic		RELIGION Catholic	
DATE OF DEATH October 1, 1957		DATE OF DEATH October 1, 1957		DATE OF DEATH October 1, 1957		DATE OF DEATH October 1, 1957		DATE OF DEATH October 1, 1957		DATE OF DEATH October 1, 1957	
PLACE OF DEATH Home		PLACE OF DEATH Home		PLACE OF DEATH Home		PLACE OF DEATH Home		PLACE OF DEATH Home		PLACE OF DEATH Home	
CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF PHYSICIAN J. H. Smith	
SIGNATURE OF REGISTRAR J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith	

BUREAU V. E.

OCT 14 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10785

10816

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>3406 Nimitz Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>BERKLEY</u> Middle <u>ATKISSON</u> Last				4. DATE OF DEATH <u>OCT. 17</u> Month <u>17</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7 - 1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Country Club</u>		11. BIRTHPLACE (State or foreign country) <u>MT. GORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHRISTOPHER COLUMBUS ATKISSON</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA HUNT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>197-24-9048</u>		17. INFORMANT <u>MRS. ERMA L ATKISSON - wife</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive heart failure</u> DUE TO <u>Myocardial insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> (c) <u>10 days</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x Bronchopneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>15 Sept</u> , 19 <u>57</u> , to <u>17 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>17 Oct</u> , 19 <u>57</u> , and that death occurred at <u>3:20 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11602 Georgia Ave. S.S. Md.</u> DATE SIGNED <u>11602-Georgia Ave. S.S. Md.</u>							
ACTUAL SIGNATURE <u>Morris Perry</u> M.D.				PHYSICIAN'S NAME (Type) <u>MORRIS PERRY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Mem. Park Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 21 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

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OCT 21 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10786

10817

CERTIFICATE OF DEATH

Reg. Dist. No.

212

1. PLACE OF DEATH COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville				c. LENGTH OF STAY IN 1b 93 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Lee Middle Aud Last				4. DATE OF DEATH Month October Day 15 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25-1863	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer & Montg. Co. employee		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Thomas Aud				14. MOTHER'S MAIDEN NAME Susan Veirs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William E. Aud, Poolesville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 14, 1949 , to 15 Oct. 1957 , that I last saw the deceased alive on 14 Oct. 1957 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin M. Smith				ADDRESS (Street, city or town, state) Barnesville, Md		DATE SIGNED 16 Oct 57	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/57		22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beall, ville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hillon Barnesville, Md				24a. REC'D BY REGISTRAR DATE 10/10/57		24b. REGISTRAR'S SIGNATURE Charles W. Elgin	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		COUNTY OF BALTIMORE DISTRICT OF BALTIMORE	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
MARITAL STATUS [Illegible]		CAUSE OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF CORONER [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF WITNESS [Illegible]	

RECEIVED
 OCT 18 1957
 BUREAU V. S.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>6006 Hemming st.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Timothy</u> Middle <u>ODEAN</u> Last <u>Baer</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 24/57</u>		9. AGE (In years last birthday) yrs. <u>4</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert C. Baer</u>				14. MOTHER'S MAIDEN NAME <u>Betty Jennings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Rev. Loyd Brown</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Respiratory Failure</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u>19</u> Hour o. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Oct 24, 1957</u> , to <u>Oct 27, 1957</u> that I last saw the deceased alive on <u>Oct 27, 1957</u> , and that death occurred at <u>10:45 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9400-11th Georgetown Rd Bethesda Md.</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>John H. Moad</u> M.D.							
PHYSICIAN'S NAME (Type) <u>John H. Moad</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 30/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 11-31-57</u>		24b. REGISTRAR'S SIGNATURE <u>Beanie M. Thompson</u>	

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

10819

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83x-3			
d. STREET ADDRESS 1545 16th Road, North				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rosalie Middle Judith Last Banks				4. DATE OF DEATH Month October Day 16 , Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 10, 1914	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Minnesota	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME David Beckman				14. MOTHER'S MAIDEN NAME Reva Freidman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INCREASED INTRACRANIAL PRESSURE 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA OF THE BREAST DUE TO (c) CARCINOMA OF THE RIGHT BREAST							INTERVAL BETWEEN ONSET AND DEATH 3 weeks 1 1/2 months 1 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemorrhage from RT Femoral artery into right thigh.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 25, 1957 , to October 16, 1957 , that I last saw the deceased alive on October 16, 1957 , and that death occurred at 2:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard K. Shaw M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 10/16/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-18-57		22c. NAME OF CEMETERY OR CREMATORY BETH ISRAEL CEMETERY		22d. LOCATION (City, town, or county) (State) WOODBRIIDGE NEW JERSEY	
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol				ADDRESS 2224 - Wisconsin Ave. D.C.		24a. REC'D BY REGISTRAR Beau M. Thompson	
				DATE 10-21-57		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 23 1957

RECEIVED

10820

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 82 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83X-3	
d. STREET ADDRESS 710 Ripley Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Meta Middle Irene Last Beatty		4. DATE OF DEATH Month October Day 19 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 25, 1914
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Willie Shine		14. MOTHER'S MAIDEN NAME Louella Holton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Melanoma 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 29, 1957 , to October 19, 1957 , that I last saw the deceased alive on October 19, 1957 , and that death occurred at 6:40a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/19/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
ACTUAL SIGNATURE Dane R. Boggs M.D.		PHYSICIAN'S NAME (Type) DANE R. BOGGS, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 21 1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Grove	22d. LOCATION (City, town, or county) (State) Newbern N. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Pumphrey ADDRESS 7557 Wisconsin Ave Bethesda Md		24a. REC'D BY REGISTRAR 10-21-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10821
 CERTIFICATE OF DEATH

10790

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORBECK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST PHILOMENA'S REST HOME				d. STREET ADDRESS 444 OAKWOOD ST SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First		Middle H		Last BEAVIN		4. DATE OF DEATH Oct 27 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 16, 1881 76 yrs.		9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. YES		17. INFORMANT DOROTHY KING Address 444 Oakwood St SE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Cerebral Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6-3 , 19 56 , to 10-27 , 19 57 , that I last saw the deceased alive on 10-24 , 19 57 , and that death occurred at 3:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry J. Kieher M.D.				ADDRESS (Street, city or town, state) 2205 Richland ST DATE SIGNED 10-27-57			
PHYSICIAN'S NAME (Type) Harry J. Kieher				Silver Springs MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		10-30-57		CEDAR HILLS		SUITLAND, MD	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS ADDRESS Co 517-11th St SE				24a. REC'D BY REGISTRAR OCT 30 1957		24b. REGISTRAR'S SIGNATURE Frances Patten	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>JOHN J. BROWN</i>		AGE <i>45</i>		SEX <i>M</i>		RACE <i>W</i>		DATE OF BIRTH <i>1910</i>		PLACE OF BIRTH <i>MD</i>	
MARRIAGE <i>1</i>		EDUCATION <i>8</i>		OCCUPATION <i>CLERK</i>		RELIGION <i>C</i>		MANNER OF DEATH <i>N</i>		CAUSE OF DEATH <i>HEART DISEASE</i>	
DATE OF DEATH <i>10/25/57</i>		PLACE OF DEATH <i>HOME</i>		TIME OF DEATH <i>10:00 AM</i>		TEMPERATURE <i>101.0</i>		PULSE <i>100</i>		RESPIRATION <i>20</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF REGISTRAR <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>	
DATE OF DEATH <i>10/25/57</i>		PLACE OF DEATH <i>HOME</i>		TIME OF DEATH <i>10:00 AM</i>		TEMPERATURE <i>101.0</i>		PULSE <i>100</i>		RESPIRATION <i>20</i>	

BUREAU V. 8

OCT 30 1957

RECEIVED

10780

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>1 8670 Piney Branch Road</u>	
3. NAME OF DECEASED (Type or print) <u>Infant</u>		4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Boy</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jack Erady Bebee</u>		14. MOTHER'S MAIDEN NAME <u>Becky Joyce Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u> (If yes, give war or dates of service) <u>-----</u>		17. INFORMANT <u>Mother's chart</u> Address <u>-----</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>9:50, 10-2, 1957</u> , to <u>11:50, 10-2-1957</u> , that I last saw the deceased alive on <u>10-2-57</u> , 19 <u>-----</u> , and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above.		
ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE <u>Ruth Standard</u> M.D. <u>Wash San + Hosp.</u>		<u>10-4-57</u>
PHYSICIAN'S NAME (Type) <u>Ruth Standard, M. D. Washington Sanitarium & Hosp. Takoma Park, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>10-3-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, Md.</u>
22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Lane</u> ADDRESS <u>Wash San & Hosp.</u>		24a. REC'D BY REGISTRAR DATE <u>10/8/57</u>
		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Bell</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075232 XVO

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text elements.

BUREAU V. 2

OCT 10 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 700 Jefferson Street, N.E.			
3. NAME OF DECEASED (Type or print) First William Middle Wayne Last BERG				4. DATE OF DEATH Month October Day 25 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Nov. 1948		9. AGE (In years last birthday) yrs. 8	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Roy BERG				14. MOTHER'S MAIDEN NAME Georgette DIEUX			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) Daniel R. BERG (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 158X DUE TO Retroperitoneal (primary site) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic sarcoma (c) 15 mo.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 24 Oct. , 19 57 , to 25 Oct. , 19 57 , that I last saw the deceased alive on 25 Oct. , 19 57 , and that death occurred at 3:55A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 10-25-57							
ACTUAL SIGNATURE Adam G. Thorp, Jr.				M.D. U.S. Naval Hospital, Bethesda, Md. 10-25-57			
PHYSICIAN'S NAME (Type) Adam G. Thorp, Jr. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md. 10-25-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-28-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James Collins Collins Funeral Home, 3821 14th St., N.W.				24a. REC'D BY REGISTRAR Washington, D.C.		24. REGISTRAR'S SIGNATURE Mary E. Casella DATE 10-25-57	

CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED
JAMES H. HARRIS

DATE OF DEATH
OCTOBER 28, 1957

PLACE OF DEATH
HARRIS, JAMES H.

AGE
70

SEX
Male

RACE
White

EDUCATION
High School

OCCUPATION
Retired

CAUSE OF DEATH
Heart Disease

IMMEDIATE CAUSE OF DEATH
Myocardial Infarction

UNDERLYING CAUSE OF DEATH
Coronary Artery Disease

PERIOD OF ILLNESS
Several Days

DATE OF BIRTH
OCTOBER 28, 1887

PLACE OF BIRTH
Baltimore, Maryland

DATE OF DEATH
OCTOBER 28, 1957

PLACE OF DEATH
HARRIS, JAMES H.

AGE
70

SEX
Male

BUREAU V. 3

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10793

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

217

10822

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 3 1/2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN				d. STREET ADDRESS 2415 SPENCER RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RALPH Middle M Last BERGER				4. DATE OF DEATH Month OCT Day 17 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC-28-1877		9. AGE (In years last birthday) 79 Yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Owner-Appliance Store		10b. KIND OF BUSINESS OR INDUSTRY NEW YORK		11. BIRTHPLACE (State or foreign country) N.Y.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MORRIS BERGER				14. MOTHER'S MAIDEN NAME ANNA (UNKNOWN)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT Hosp Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal hemorrhages DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fractured pelvis, lacerated spleen & liver DUE TO (c) Traumatic injuries							INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compound fracture both legs							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian - Struck by car, while crossing highway					
20c. TIME OF INJURY Hour 6:24 a.m. Month, Day, Year 10-7-1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Silver Spring Maryland MD			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Brontant				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BRONTANT				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-17-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D. C.				24a. REC'D BY REGISTRAR OCT 21 1957			
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE

CITY

COUNTY

DATE

TIME

CAUSE OF DEATH

BUREAU V. E.

OCT 21 1957

RECEIVED

10823

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>N.Y.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <i>8509 Arapac Ave. Cherry Chase</i>				d. STREET ADDRESS <i>W. 106th St.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Milton</i> First <i>Berlinger</i> Middle Last				4. DATE OF DEATH Month <i>Oct</i> Day <i>31</i> Year <i>1957</i>			
5. SEX <i>M.</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/27-1876</i>	
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Retired Salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Jacob Berlinger</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Sra A Schulman</i> Address <i>son in law</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Hemorrhage (Trauma)</i> <i>162x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Extensive Bronchogenic Carcinoma</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 20</i> , 1957, to <i>Oct 31</i> , 1957, that I last saw the deceased alive on <i>Oct 31</i> , 1957, and that death occurred at <i>3:00 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Michael R. Toliver</i>				ADDRESS (Street, city or town, state) <i>10620 Georgian SS Rd.</i> DATE SIGNED <i>Oct 31, 1957</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>11/3-1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Beth El Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Long Island N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i> ADDRESS <i>4217 9th St NW</i>				24a. REC'D BY REGISTRAR <i>DATE 11-2-57</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 5 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

216

10824

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, 47x-3			
f. STREET ADDRESS 1241 Valley Avenue, S.E.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Casimir Joseph Biegalski				4. DATE OF DEATH Month Day Year October 22 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1906	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Stanley Biegalski				14. MOTHER'S MAIDEN NAME Martha Ulatowski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 578-30-9501		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH one week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC LYMPHOBLASTIC LEUKEMIA, CHRONIC GLOMERULONEPHRITIS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 21, 1957 , to October 22, 1957 , that I last saw the deceased alive on October 22, 1957 , and that death occurred on October 22, 1957 , at 4:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/23/57							
ACTUAL SIGNATURE Richard K. Shaw M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-57		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home Washington D.C.				24a. REC'D BY REGISTRAR 25 1957 24b. REGISTRAR'S SIGNATURE Leslie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 25 1957

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,310 Bluehill Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
		d. STREET ADDRESS 12,310 Bluehill Road	
3. NAME OF DECEASED (Type or print) 100 First Rogers Bird		4. DATE OF DEATH 10 2 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/10/81
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jim Rogers		14. MOTHER'S MAIDEN NAME Marjorie (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Daughter - 12310 Bluehill Rd. S.S.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. None 19 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/2 , 19 57 , to 10/2 , 19 57 , that I last saw the deceased alive on 10/2 , 19 57 , and that death occurred at 1230 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Umhau M.D.		ADDRESS (Street, city or town, state) 8805 Conn. Ave	
DATE SIGNED 10/2/57			
PHYSICIAN'S NAME (Type) JOHN B. UMHAU Chevy Chase MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL	22b. DATE THEREOF 10/7/57	22c. NAME OF CEMETERY OR CREMATORY MEMORIAL CEMETERY	22d. LOCATION (City, town, or county) (State) WEST PALM BEACH, FLORIDA
23. FUNERAL DIRECTOR'S SIGNATURE Wanner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR 4 1957		24b. REGISTRAR'S SIGNATURE Frances Patter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10238

NAME OF DECEASED Mary Ann ...		SEX Female	
AGE 60 years		RACE White	
PLACE OF BIRTH ...		DATE OF BIRTH ...	
PLACE OF DEATH ...		DATE OF DEATH ...	
CAUSE OF DEATH ...		MANNER OF DEATH ...	
SIGNATURE OF PHYSICIAN ...		SIGNATURE OF REGISTRAR ...	
SIGNATURE OF DECEASED ...		SIGNATURE OF WITNESS ...	

BUREAU V. S.

OCT 4 1937

RECEIVED

10826

CERTIFICATE OF DEATH

10797.
Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Louisiana b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Orleans 56x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 1325 Broadway Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Patricia Middle Ripp Last BITTENBRING				4. DATE OF DEATH Month October Day 15 Year 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 March 1926		9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Martin RIPP				14. MOTHER'S MAIDEN NAME Blanche FISHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Husband) Charles BITTENBRING			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Stem Disease 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Most likely Multiple Sclerosis) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7 August , 19 57 , to 15 Oct. , 19 57 , that I last saw the deceased alive on 15 Oct. , 19 57 , and that death occurred at 6:12 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE M. H. Lampert				M.D. U.S. Naval Hospital, Bethesda, Md. 10-16-57			
PHYSICIAN'S NAME (Type) M. H. LAMPERT, LT.MC,USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) New Orleans, Louisiana	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 10-16-57	
				24b. REGISTRAR'S SIGNATURE Mary C. Parnelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10781

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospt.</u>				d. STREET ADDRESS <u>1800 N. Potomac Ave. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Augusta</u> Last <u>Bond</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25, 1884</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>57</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>57</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Potent Researcher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edwin H. Bond</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Robertson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hospital Records</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Ascending Colon with metastases</u> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases</u> DUE TO (c) <u>metastases</u> INTERVAL BETWEEN ONSET AND DEATH <u>Aug. 15, 1957</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>153X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept. 4, 1957</u> to <u>Oct. 16, 1957</u> , that I last saw the deceased alive on <u>Oct. 16, 1957</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Willard Camalier, M.D.</u>				ADDRESS (Street, city or town, state) <u>1801-Eye St. N.W., Wash. 6, D.C.</u>			
DATE SIGNED <u>10/16/57</u>				DATE SIGNED <u>10/16/57</u>			
PHYSICIAN'S NAME (Type) <u>C. WILLARD CAMALIER, M.D.</u>				Wash. 6, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>			
24a. REC'D BY REGISTRAR <u>G. Wilson</u>				24b. REGISTRAR'S SIGNATURE <u>G. Wilson</u>			
DATE <u>OCT 22 1957</u>				DATE <u>OCT 22 1957</u>			

CERTIFICATE OF DEATH

PLACE IN DEATH		MARRIAGE	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION	
7. CAUSE OF DEATH		8. PLACE OF DEATH	
9. TIME OF DEATH		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED	
23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED	
27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED	
35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED	
39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF DECEASED	
47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED	
59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED	
63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED	
75. SIGNATURE OF DECEASED		76. SIGNATURE OF DECEASED	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED	
83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED	
87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED	
95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	

BUREAU V. B.

OCT 22 1957

RECEIVED

10827

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Springfield</u> 88 X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Nowood Rd</u>			d. STREET ADDRESS <u>6814 Front Royal Road</u>		
3. NAME OF DECEASED (Type or print) <u>Willis F. Bond</u>			4. DATE OF DEATH <u>10-2-57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-14</u>		9. AGE (In years last birthday) <u>43</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cool</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.F.</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Active duty</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>U.S.A.F. Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries Extremes</u> 860 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Body badly mutilated & burned</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Airplane Accident</u>			
20c. TIME OF INJURY Month, Day, Year <u>2:00 p.m. 10-2-57</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Roby Farm</u>	
				20f. (City or town) <u>Silver Spring, Md</u> (County) <u>Montgomery</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Bosenant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-2-57</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Bosenant</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Columbus Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. 517-11th St. S.E.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 7 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

RECEIVED
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10800

10828

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Louisiana b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 78 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bossier City 56X-3			
d. STREET ADDRESS 2718 Foster Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hellon Middle Geraldine Last Branton				4. DATE OF DEATH Month October Day 19 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 2, 1932	
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Louisiana	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Clinton Bison				14. MOTHER'S MAIDEN NAME Grace Chevalier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Primary pulmonary hypertension DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 6 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 2 , 19 57 , to October 19 , 19 57 , that I last saw the deceased alive on October 19 , 19 57 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/20/57 ACTUAL SIGNATURE James C. Allen M.D. National Institutes of Health PHYSICIAN'S NAME (Type) JAMES C. ALLEN, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, OR OTHER DISPOSAL Burial-Transit		22b. DATE THEREOF 10/20/57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Marshall, Texas	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 10-21-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

ALABAMA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL ATTENDANT [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF MEDICAL ATTENDANT [REDACTED]	
SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF NOTARY [REDACTED]	

BUREAU V. S.

OCT 23 1957

RECEIVED

10829

CERTIFICATE OF DEATH

Reg. Dist. No.

108012/2

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Poolesville				c. LENGTH OF STAY IN 1b x2 Rural-Potomac			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS Rt. #3, Bethesda, Md.	
3. NAME OF DECEASED (Type or print) First EMMA Middle ELIZABETH Last BRAZILL				4. DATE OF DEATH Month October Day 18 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/25/1870	9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 23 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Wellmeyer				14. MOTHER'S MAIDEN NAME Sophie Ahrens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James J. Brazil-Rt. 3, Bethesda, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio Sclerosis DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 56 , to 18 Oct , 19 57 , that I last saw the deceased alive on 17 Oct , 19 57 , and that death occurred at 12¹⁵ A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md DATE SIGNED 18 Oct. 57							
ACTUAL SIGNATURE Gorden N. Smith				M.D. Barnesville, Md.			
PHYSICIAN'S NAME (Type) Gorden N. Smith				Barnesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 10/18/57		22c. NAME OF CEMETERY OR CREMATORY St. Peters		22d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE Chas Elgins			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 21 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

OCT 21 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Kenneth Middle Virgil Last BRIERLY				4. DATE OF DEATH Month October Day 28 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Sept. 1921	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Streator, Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Elmer BRIERLY				14. MOTHER'S MAIDEN NAME Nellie HILTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes (Currently)				16. SOCIAL SECURITY NO. 320-34-6213		17. INFORMANT (Wife) Mrs. Mary Maxine BRIERLY (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured aneurysm DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 21-30 hours							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 Oct. 19 57 , to 28 Oct. 19 57 , that I last saw the deceased alive on 28 Oct. 19 57 , and that death occurred at 6:06 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 10-29-57							
ACTUAL SIGNATURE M. H. Lampert M.D. U.S. Naval Hospital, Bethesda, Md. 10-29-57							
PHYSICIAN'S NAME (Type) M. H. LAMPERT, LT, MC, USN U.S. Naval Hospital, Bethesda, Md. 10-29-57							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-2-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Streator, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Chambers, 1400 Chapin St., N.W. Washington, D.C.				24a. REC'D BY REGISTRAR DATE 10-29-57			
24b. REGISTRAR'S SIGNATURE Mary S. Russell							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU A. B.

OCT 30 1957

RECEIVED

CERTIFICATE OF DEATH

10803

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>Rfd-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bettie</u> First <u>Mary</u> Middle <u>Briggs</u> Last				4. DATE OF DEATH Month <u>Oct</u> - Day <u>2</u> - Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June-27-1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house - wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>house - keeping</u>		11. BIRTHPLACE (State or foreign country) <u>Gaithersburg, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>James A. Mills</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Fred T. Briggs, Gaithersburg, Md. Rfd 3</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> <u>331X</u> DUE TO (b) <u>High Arterial Tension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cerebral arterio-sclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>few hours</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> 19 <u>57</u> , to <u>Oct-2-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Sept-24-</u> 19 <u>57</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7-Brooks Ave., Gaithersburg, Md.</u> DATE SIGNED <u>William C. Miller</u>							
ACTUAL SIGNATURE <u>William C. Miller</u> M.D.							
PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>				<u>Gaithersburg, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund E. Garton</u> ADDRESS <u>Gaithersburg, Md</u>				24a. REC'D BY REGISTRAR <u>Abraham G. Cook</u>		24b. REGISTRAR'S SIGNATURE <u>Abraham G. Cook</u>	

BUREAU V.

7 OCT 1957

RECEIVED

10832

CERTIFICATE OF DEATH

10894
274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilee Nursing Home 14511 Colesville Rd.				d. STREET ADDRESS 4526 Livingston Rd., S.E.			
3. NAME OF DECEASED (Type or print) First Edith Middle Mario Last Brown				4. DATE OF DEATH 10/7/57 Month Day Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/3/1870	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME George W. Crotchley				14. MOTHER'S MAIDEN NAME Sarah E. Kidwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Nursing Home Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral ischemia 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Cerebral A.S.						INTERVAL BETWEEN ONSET AND DEATH 1 day 12 day Indef.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/25/57 , 19 57 , to 10/7/57 , 19 57 , that I last saw the deceased alive on 10/7/57 , 19 57 , and that death occurred at 3:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen R. Jones M.D.				ADDRESS (Street, city or town, state) Rockville Md		DATE SIGNED 10/7/57	
PHYSICIAN'S NAME (Type)							
22a. BURIAL CREMATION REMOVAL burial		22b. DATE THEREOF 10/11/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				ADDRESS Wash, D.C.		24a. REC'D BY REGISTRAR Oct 9 1957	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX Male	
AGE 45		RACE White	
DATE OF DEATH 10/15/57		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS Married		NAME OF SPOUSE [Faint text, possibly "Jane Doe"]	
NAME OF PHYSICIAN [Faint text, possibly "Dr. John Smith"]		NAME OF HOSPITAL [Faint text, possibly "St. Mary's Hospital"]	
NAME OF FUNERAL HOME [Faint text, possibly "The Funeral Home"]		NAME OF BURIAL PLACE [Faint text, possibly "Greenwood Cemetery"]	

BUREAU V. 2

OCT 9 1957

RECEIVED

THE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Terry Middle Lynn Last Buckler				4. DATE OF DEATH Month October Day 29 , Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1956	
9. AGE (In years lost birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Howard Buckler			
14. MOTHER'S MAIDEN NAME Doris Posey				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fibrocystosis of Heart DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr 36 min 13 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 27, 1957 , to October 29, 1957 , that I last saw the deceased alive on October 29, 1957 , and that death occurred at 8:06 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/30/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE John A. Waldhausen, M. D.				PHYSICIAN'S NAME (Type) John A. Waldhausen, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 31, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Joseph		22d. LOCATION (City, town, or county) (State) Morganza, Md. St. Mary's Co.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingly, Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 10/31/57		24b. REGISTRAR'S SIGNATURE Alan D. Houser Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 12

RECEIVED
NOV 1 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10806
Reg. Dist. No. 276

10834

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>D.C.</u> <u>47X-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George H. Burrier</u>				4. DATE OF DEATH Month <u>10</u> - Day <u>10</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1893</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Linotype printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New Paper</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Burrier</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hepburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-07-7242</u>		17. INFORMANT Address <u>Helen Burrier (wife) Stee 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				DATE SIGNED <u>10-10-57</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <u></u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grand Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Lakeside Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chuan Jones</u> ADDRESS <u>5103 St. Anns</u>				24a. REC'D BY REGISTRAR <u>10-16-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

OCT 18 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10807

10835

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived / If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1625 Bonifant Road</u>		d. STREET ADDRESS <u>1625 Bonifant Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Glennwood</u> Last <u>BURRIS</u>		4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 19th 1900</u> <u>57</u> yrs.
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Burris</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Gates</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>	
16. SOCIAL SECURITY NO. <u>578-03-2732</u>		17. INFORMANT Address <u>Mrs. Virgie Estelle Burris</u> Item <u>2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 yrs.</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Oct 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>57</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Spring, Md 10/8/57</u>			
ACTUAL SIGNATURE <u>A. D. Bonifant</u>		M.D. <u>Sandy Spring, Md 10/8/57</u>	
PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md</u>	24. REGISTRAR'S SIGNATURE <u>Frances Potter</u>
24a. REC'D BY REGISTRAR DATE <u>19</u> 19 <u>57</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		CITY OF RESIDENCE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
NAME OF PHYSICIAN [Faint text]		NAME OF CORONER [Faint text]	
NAME OF FUNERAL HOME [Faint text]		NAME OF BURIAL PLACE [Faint text]	
NAME OF NEXT OF KIN [Faint text]		NAME OF WITNESS [Faint text]	
NAME OF REGISTRAR [Faint text]		NAME OF CLERK [Faint text]	

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 OCT 9 1957
 BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10836

CERTIFICATE OF DEATH

10808
Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1203 N. Chambliss Street			
3. NAME OF DECEASED (Type or print) First Keller Middle Young Last BUZHARDT				4. DATE OF DEATH Month October Day 29 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 June 1922	
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME George Elbert Young				14. MOTHER'S MAIDEN NAME Ruth Mc Crackin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Harry O. BUZHARDT (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary edema 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia left lower lobe DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH immediate 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 28 October, 19 57 to 29 October, 19 57 , that I last saw the deceased alive on 29 October, 19 57 , and that death occurred at 6:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 10-29-57							
ACTUAL SIGNATURE J. T. Horgan				M.D. U.S. Naval Hospital, Bethesda, Md. 10-29-57			
PHYSICIAN'S NAME (Type) J. T. Horgan, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md. 10-29-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-1-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Whitmire, South Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 10-30-57			
				24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10837

CERTIFICATE OF DEATH

10809 217
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 13 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kathleen Middle — Last Carter		4. DATE OF DEATH Month October Day 24 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/57
9. AGE (In years last birthday) yrs. 13		IF UNDER 1 YEAR Months — Days — Hours — Min —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Raymond Herbert Carter		14. MOTHER'S MAIDEN NAME Mary Elizabeth Gant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mary E. Gant		Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fetal atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumothorax DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/24 , 19 57 , to 10/24 , 19 57 , that I last saw the deceased alive on 10/24 , 19 57 , and that death occurred at — M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. D. Bonifant		ADDRESS (Street, city or town, state) Sandy Spring, Md.	
PHYSICIAN'S NAME (Type) A. D. Bonifant, M. D.		DATE SIGNED 10/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Mt. Zion, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE 10/29/57		24b. REGISTRAR'S SIGNATURE Gustave Lawler	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10810

Reg. Dist. No.

2/3

10808

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 30 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carlo St.				d. STREET ADDRESS 613 Douglas Ave.			
3. NAME OF DECEASED (Type or print) First William Randolph Middle Carter Last				4. DATE OF DEATH Month 10/3/57 Day Year 19			
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/12/1906		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Lillie Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Albert Harper, Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Fell dead on street	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/4/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert L. Suorden Rockville, Md.				24a. REC'D BY REGISTRAR DATE 8 1957		24b. REGISTRAR'S SIGNATURE Lawrence K. Taylor	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10838

CERTIFICATE OF DEATH

10811

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL)				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, NMMC,				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 47X-3			
3. NAME OF DECEASED (Type or print) First ROSARIO Middle (N) Last CATALDO				4. DATE OF DEATH Month OCTOBER Day 5 Year 1957			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 May 1874	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUC USN RET.				10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) ITALY	
13. FATHER'S NAME PET CATALDO				14. MOTHER'S MAIDEN NAME MARY CARALGIA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I WW II				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT OFFICIAL NAVAL RECORDS Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF LEFT MIDDLE CEREBRAL ARTERY #5160 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 SEPT. , 19 57 , to 5 OCTOBER , 19 57 , that I last saw the deceased alive on 5 OCTOBER , 19 57 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William J. Jacoby, Jr. M.D.				U.S. NAVAL HOSPITAL, NMMC, BETHESDA, MD. 6 OCTOBER 1957			
PHYSICIAN'S NAME (Type) JACOBY, W.J. Jr. LT MC USN				U.S. NAVAL HOSPITAL, NMMC, BETHESDA, MD.			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9 OCT. 1957		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE A.C. HUNTEMANN ADDRESS 5732 GEORGIA AVE. WASH. D.C.				24a. REC'D BY REGISTRAR Mary E. Parrelly		24b. REGISTRAR'S SIGNATURE	

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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BUREAU V. S.

7961 OCT 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10812

Reg. Dist. No.

214

10839

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b
<u>8 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>10418 Inwood Ave.</u> | | | | d. STREET ADDRESS
<u>10418 Inwood Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>James</u> Middle <u>McCreight</u> Last <u>Cathcart, Sr.</u> | | | | 4. DATE OF DEATH
Month <u>October</u> Day <u>14</u> Year <u>1957</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb. 22, 1886</u> | | 9. AGE (in years last birthday)
<u>71</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clerk - Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Government</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Florida</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>James M. Cathcart</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Dorcas Tillman</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
<u>Mr. James M. Cathcart, Jr.</u> Address <u>Item 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Hypertension</u>
DUE TO
(c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u>
<u>8 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour <u> </u> a. m. <u> </u> p. m. <u> </u>
Month, Day, Year <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Brochart</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Dr. Frank J. Brochart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/14/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10/17/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Woodlawn Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Tampa, Florida</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner E. Humphrey, Inc.</u> | | | | ADDRESS
<u>Silver Spring, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>OCT 17 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Francis Piller</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

OCT 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G221 10-29-57 et

CERTIFICATE OF DEATH

10840

10813

Reg. Dist. No. 214

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland
b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington | | c. LENGTH OF STAY IN 1b
15 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Kensington Gardens Sanitarium | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Antoinette Middle D Last Chase | | 4. DATE OF DEATH
Month Oct. Day 16 Year 1957 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 4, 1873 |
| 9. AGE (In years last birthday)
84 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Thomas Davis | | 14. MOTHER'S MAIDEN NAME
Sallie Hall | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Home Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile Arteriosclerosis
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
3 days
10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour o. s. p. m. Month, Day, Year
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7-4 , 19 56 , to 10-16 , 19 57 , that I last saw the deceased alive on 10-16-57 , and that death occurred at 9:57 M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 7112 Willow Ave
DATE SIGNED | | | |
| ACTUAL SIGNATURE H. B. Queen | | M.D. 7112 Willow Ave | |
| PHYSICIAN'S NAME (Type) H. B. QUEEN | | Takoma Park Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/19/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Glenwood Cemetery | | 22d. LOCATION (City, town, or county) (State)
Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S. H. Niles Co. | | 24. REC'D BY REGISTRAR
22 1957 | |
| ADDRESS
2901-14 St. N.W. | | 24b. REGISTRAR'S SIGNATURE
Frances Patter | |

BUREAU A. M.

di - 2000

10-10-2615

1957 22 OCT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10841

CERTIFICATE OF DEATH

10814

Reg. Dist. No. 215

| | | | |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. LENGTH OF STAY IN 1b
3 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Maryland | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington 47x-3 | |
| 3. NAME OF DECEASED (Type or print)
First Anice Middle Faye Last CHASE | | 4. DATE OF DEATH
Month October Day 10 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
14 June 1920 |
| 9. AGE (In years last birthday)
37 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
None | 11. BIRTHPLACE (State or foreign country)
West Virginia |
| 13. FATHER'S NAME
Leonard A. King | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unknown | 17. INFORMANT
Husband, Garnet W. CHASE (Same As #2) |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Adenocarcinoma of Rt. Breast
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
Indefinite | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 7 Oct. , 19 57 , to 10 Oct. , 19 57 , that I last saw the deceased alive on 10 Oct. , 19 57 , and that death occurred at 3:06 P. M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE C. R. Boyce M.D. U.S. Naval Hospital, Bethesda, Md. 10-10-57
PHYSICIAN'S NAME (Type) C. R. BOYCE, LT, MC, USN U.S. Naval Hospital, Bethesda, Md. 10-10-57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10-14-57 | 22c. NAME OF CEMETERY OR CREMATORY
Rose Wood Cemetery | 22d. LOCATION (City, town, or county) (State)
Lewisburg, West, Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R. A. Pumphrey | | 24a. REC'D BY REGISTRAR
10-10-57 | 24b. REGISTRAR'S SIGNATURE
Mary E. Savelly |

BUREAU A. 2

OCT 14. 1957

RECEIVED

10782

CERTIFICATE OF DEATH

Reg. Dist. No.

273

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
<u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
<u>Maryland</u>
b. COUNTY
<u>Prince George</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Riverdale</u>
1625.2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Washington San. & Hospital</u> | | | | d. STREET ADDRESS
<u>6129 58th Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Theodore Apolstal Chekalos</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>10 11 1957</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>5-5-81</u> | |
| 9. AGE (In years last birthday)
<u>76</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>owner</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Hotel Operator</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Greece</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Apolstal Chekalos</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Harris</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>no</u> | | | | 16. SOCIAL SECURITY NO.
<u>son</u> | | | |
| 17. INFORMANT
<u>Paul Chekalos</u> | | | | Address
<u>6127 58th Ave. Riverdale, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial failure</u>
<u>157X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cachexia</u>
DUE TO (c) <u>Adenocarcinoma Pancreas</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>9 mo.</u>
<u>13 mo.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>October</u> , 19 <u>56</u> , to <u>10-11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-11-57</u> , and that death occurred at <u>3:01 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Med. Examiner</u> M.D. | | | | ADDRESS (Street, city or town, state)
<u>8005 Woodbury Dr. Silver Spring, Md.</u> | | | |
| DATE SIGNED
<u>10-11-57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type)
<u>Silver Spring, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL, SPECIFY
<u>burial</u> | | 22b. DATE THEREOF
<u>10/14/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Glenwood Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>She S. H. Niner Co</u> | | | | ADDRESS
<u>2901 14th St N.W. D.C.</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 15 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Walter Laddy</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 17 1957

RECEIVED

10842

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|----------------------------------|--|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b
24 days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Alexandria 83X-3 | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Maryland | | | |
| d. STREET ADDRESS
200 Lafayette Drive | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First Lillian Middle Juliet Last CLARKE | | 4. DATE OF DEATH | | Month October Day 4 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
27 Oct. 1901 | | 9. AGE (In years last birthday) yrs. 55 | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Massachusetts | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Henry M. CLAPP | | | | 14. MOTHER'S MAIDEN NAME
Lucinda MONTAGUE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT Address
(Husband) Edwin C. CLARKE (Same As #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Left Colon with extensive metastasis to liver and peritoneum
DUE TO (b) approx 12 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11 Sept. , 19 57 , to 4 Oct. , 19 57 , that I last saw the deceased alive on 3 Oct. , 19 57 , and that death occurred at 3:40 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
U.S. Naval Hospital, Bethesda, Md. 10-4-57 | | | | | | | |
| ACTUAL SIGNATURE
Robert P. Dobbie, Jr. | | | | M.D. U.S. Naval Hospital, Bethesda, Md. 10-4-57 | | | |
| PHYSICIAN'S NAME (Type) Robert P. Dobbie, Jr., CDR, MC, USN U.S. Naval Hospital, Bethesda, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-7-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington Natl Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wheatley Funeral Home, 809 King St. Alexandria, Virginia | | | | 24a. REC'D BY REGISTRAR
DATE 10-4-57 | | 24b. REGISTRAR'S SIGNATURE
Mary E. Parrelly | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

OCT 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10843

CERTIFICATE OF DEATH

10817

Reg. Dist. No. 218

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WashingtonGrove.Md | | c. LENGTH OF STAY IN 1b
27yr | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WashingtonGrove. RF D x2 | |
| d. STREET ADDRESS
1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Anna Middle Catherine Last Clavin | | 4. DATE OF DEATH
Month Oct Day 25 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug 30-1897 |
| 9. AGE (In years last birthday)
60 yrs. | | IF UNDER 1 YEAR
Months 1 Days 25 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Keeping | | 10b. KIND OF BUSINESS OR INDUSTRY
Home work | |
| 11. BIRTHPLACE (State or foreign country)
Phionixville. Pa, | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Elwood C. Clavin | | 14. MOTHER'S MAIDEN NAME
Edith T. Achenbach | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Leo H. Achenbach | | Address
WashingtonGrove.Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure
170x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of lungs (Metastatic)
DUE TO
(c) from Carcinoma of Right Breast | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
(Smoking) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. 11 p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/15/57 , 19 57 , to 10/25 , 19 57 , that I last saw the deceased alive on Oct 10 , 19 57 , and that death occurred at M , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Luciano L. Leal M.D. | | | |
| PHYSICIAN'S NAME (Type) Luciano L. Leal Gaithersburg Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF
10-28-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Forest Oak | | 22d. LOCATION (City, town, or county) (State)
Gaithersburg. Md, | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ernest C. Gartner. Gaithersburg. Md, | | 24a. REC'D BY REGISTRAR
DATE Oct 28-57 | |
| 24b. REGISTRAR'S SIGNATURE
Abraham L. Cook | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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|---------------------|--|--------|--|--------|--|---------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|-------------------|--|---------------------|--|----------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF DECEASED | |
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10818/4

10844

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|--|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wheaton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wheaton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
12106 Good Hill Road | | d. STREET ADDRESS
12106 Good Hill Road | |
| 3. NAME OF DECEASED (Type or print)
Margaret Ellen Compher | | 4. DATE OF DEATH
Month October Day 6 Year 1957 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/29/74 |
| 9. AGE (In years last birthday)
83 | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Taylor's Town, Va. | |
| 11. BIRTHPLACE (State or foreign country)
Taylor's Town, Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Samuel Snoots | | 14. MOTHER'S MAIDEN NAME
Ellen Williams | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Marie Marks | | Address
12106 Good Hill Rd. Wheaton Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension
DUE TO
(c) Hypertension | | | INTERVAL BETWEEN ONSET AND DEATH
2 days
12 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 1 , 19 57 , to Oct. 6 , 19 57 , that I last saw the deceased alive on Oct 6 , 19 57 , and that death occurred at 6:35 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
W. Smith | | ADDRESS (Street, city or town, state) DATE SIGNED
13018 Georgia Ave. Silver Spring, Md. | |
| PHYSICIAN'S NAME (Type)
W. Smith | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 22b. DATE THEREOF
10/9/57 | 22c. NAME OF CEMETERY OR CREMATORY
Union Cemetery | 22d. LOCATION (City, town, or county) (State)
Lovettsville, Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H. Hines Co. | | 24a. REC'D BY REGISTRAR
10 OCT 8 1957 | |
| 24b. REGISTRAR'S SIGNATURE
Innes Pottery | | | |

RECEIVED

1957 OCT 5

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG222 10-29-57 et

CERTIFICATE OF DEATH

10783

10819 723
Reg. Dist. No.

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|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 1 mo 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. & Hosp. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Virginia
b. COUNTY Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna
d. STREET ADDRESS 620 Spring St
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Milton George Conger | | | | 4. DATE OF DEATH
Month Oct Day 11 Year 1957 | | | |
| 5. SEX M | | 6. COLOR OR RACE Wh | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-12-92 | |
| 9. AGE (In years last birthday) 65 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister | | 11. BIRTHPLACE (State or foreign country) D.C. | | 12. CITIZEN OF WHAT COUNTRY? Amer | |
| 13. FATHER'S NAME George Conger | | | | 14. MOTHER'S MAIDEN NAME Burke, Catherine | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 153X | | 17. INFORMANT Washington Sanatorium & Hosp Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 153X
DUE TO Transition
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Cervix with Metastasis
DUE TO (c) 10 mos | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 mos | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from Oct 10, 1956 to Oct 11, 1957 , that I last saw the deceased alive on Oct 10, 1957 , and that death occurred at 1:09 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Robert A. Hare M.D. | | | | ADDRESS (Street, city or town, state) Takoma Park, Md. | | | |
| DATE SIGNED 10/11/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) Robert A. Hare | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 13, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Elk Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Oakton Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters | | | | ADDRESS 254 Carroll St NW. D.C. | | 24a. REC'D BY REGISTRAR OCT 14 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE J. Nelson Saddy | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|--|--|
| NAME OF DECEASED
[Faint text, possibly "JOHN J. ..."] | | SEX
[Faint text, possibly "M"] | | AGE
[Faint text, possibly "45"] | |
| PLACE OF BIRTH
[Faint text, possibly "NEW YORK, N.Y."] | | DATE OF BIRTH
[Faint text, possibly "JAN 15 1912"] | | PLACE OF DEATH
[Faint text, possibly "BOSTON, MASS."] | |
| OCCUPATION
[Faint text, possibly "LABORER"] | | CAUSE OF DEATH
[Faint text, possibly "HEART DISEASE"] | | MANNER OF DEATH
[Faint text, possibly "NATURAL"] | |
| DATE OF DEATH
[Faint text, possibly "OCT 10 1957"] | | TIME OF DEATH
[Faint text, possibly "10:30 AM"] | | PLACE OF INTERMENT
[Faint text, possibly "CATHOLIC CEMETERY"] | |
| SIGNATURE OF PHYSICIAN
[Faint signature] | | SIGNATURE OF REGISTRAR
[Faint signature] | | SIGNATURE OF DECEASED
[Faint signature] | |

BUREAU V. S.

OCT 14 1957

RECEIVED

10784

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Disl. No.

773

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| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Price George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | c. LENGTH OF STAY IN 1b
4 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland 1615-2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington Sanitarium & Hospital | | | | d. STREET ADDRESS
5001 - 37th Place | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Frances Middle Jane Last Coulter | | | | 4. DATE OF DEATH
Month 10 Day 16 Year 1957 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Cauc. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-9-01 | |
| 9. AGE (In years last birthday)
55 yrs. | | IF UNDER 1 YEAR
Months 55 Days 55 | | IF UNDER 24 HRS.
Hours 55 Min. 55 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk-Steno. | | 10b. KIND OF BUSINESS OR INDUSTRY
Government | | 11. BIRTHPLACE (State or foreign country)
Indiana | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles C. Coulter | | | | 14. MOTHER'S MAIDEN NAME
Minnie Schoil | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
Yes--unknown | | 17. INFORMANT
Itosp. Record Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism
825X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of 5th & 6th Dorsal Vertebrae
DUE TO (c) Auto accident | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 1/2 mo | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Multiple fracture ribs | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Driver of auto - no other record | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. 8-31 1957
p. m. | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
? | | 20f. (City or town) (County) (State)
Freshman Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) FRANK J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 10-16-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/21/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State)
Prince George Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Warner E. Humphrey | | | | ADDRESS
Silver Spring, Md | | 24a. REC'D BY REGISTRAR
W. H. D. D. D. | |
| | | | | 24b. REGISTRAR'S SIGNATURE
W. H. D. D. D. | | DATE
OCT 22 1957 | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

OCT 22 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 214

10845

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
56 SILVER SPRING | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
14 Wessex Road | | | | d. STREET ADDRESS
14 Wessex Road | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) Annie R. Cranford | | | | 4. DATE OF DEATH
Month OCTOBER Day 31 Year 19 57 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/6/76 | |
| 9. AGE (In years last birthday)
81 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Gov't. Clerk & School Teacher | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Teacher | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
John Williamson | | | | 14. MOTHER'S MAIDEN NAME
Mary Lacey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Mr. John L. Cranford, 14 Wessex Rd., Silver Spring, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 181X Uremia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of bladder
DUE TO
(c) 8 mos | | | | INTERVAL BETWEEN ONSET AND DEATH
2 mos | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive failure | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar 1956 to Oct 30 1957 , that I last saw the deceased alive on Oct 30 1957 , and that death occurred at 3:40 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Wash. San. & Hospital, Takoma Park, Md. DATE SIGNED 10/31/57 | | | | | | | |
| ACTUAL SIGNATURE Raymond O. West | | | | PHYSICIAN'S NAME (Type) RAYMOND O. WEST | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
11/2/57 | | 22c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 22d. LOCATION (City, town, or county) (State)
SUITLAND, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Warner E. Humphrey | | | | 24. REC'D BY REGISTRAR
DATE NOV 1 1957 | | 24b. REGISTRAR'S SIGNATURE
Francis Potter | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registration or prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 4

NOV 1 1957

RECEIVED

10846

CERTIFICATE OF DEATH

| | | | | | | | |
|---|-------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>D.C.</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | | | c. LENGTH OF STAY IN 1b <u>15 days 9hr's</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u> | | | | d. STREET ADDRESS <u>6350 31st. St. N.W.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>EMIL</u> Middle <u>---</u> Last <u>CRITCHFIELD</u> | | | | 4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>8</u> Year <u>1957</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV. 3rd, 1893</u> | | 9. AGE (In years last birthday) <u>63</u> yrs. | | IF UNDER 1 YEAR
Months <u>11</u> Days <u>5</u> Hours <u>---</u> Min. <u>---</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROPRIETOR OF GAS STATION (RETIRED)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OHIO</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | |
| 13. FATHER'S NAME <u>JASON CRITCHFIELD</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CLARA BROWN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR I</u> | | | | 16. SOCIAL SECURITY NO. <u>578-46-7514</u> | | 17. INFORMANT Address <u>WASH., D.C.</u>
<u>ESTHER A. CRITCHFIELD 6350 31st. ST. N.W.</u> | |
| 18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>
<u>155x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last:
(b) <u>Generalized toxemia</u>
DUE TO
(c) <u>Carcinoma, Ampulla Vater, Status postoperative</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>8 hours.</u>
<u>24 hours.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. <u>11</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>54</u> , to <u>10-8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 8</u> , 19 <u>57</u> , and that death occurred at <u>1:00AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Alfred S. Norton</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>4711 Highland Ave Bethesda Md</u> DATE SIGNED <u>10/8/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Alfred S. Norton, M.D.</u> | | | | 4711 Highland Ave. Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/10/1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Be th. Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 10-9-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Horn</u> | |

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi 16 X 2.2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | d. STREET ADDRESS <u>7900 New Riggs Rd.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Baby Boy</u> Middle <u>Crockett</u> Last <u>Crockett</u> | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>7</u> Year <u>1957</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 7/57</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>David Samuel Crockett</u> | | 14. MOTHER'S MAIDEN NAME <u>Patricia Nau</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 17. INFORMANT <u>Mother - Same</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Prematurity</u>
<u>774X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to spontaneous delivery @ 26 weeks' gestation</u>
DUE TO (c) <u>2 hours</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct 7, 1957</u> to <u>Oct 7, 1957</u> , that I last saw the deceased alive on <u>October 7, 1957</u> , and that death occurred at <u>6:55 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Thomas M. Wilson</u> M.D. | | ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave, Bethesda, MD</u> | |
| PHYSICIAN'S NAME (Type) <u>Thomas M. Wilson, MD</u> | | <u>8218 Wisconsin Ave, Bethesda, MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Cremation (for security)</u> | <u>? Sent to:</u> | <u>The N. I. of H.</u> | <u>Bethesda, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24b. REGISTRAR'S SIGNATURE | |
| | | <u>Bessie Thompson</u> | |

BUREAU V. 3.

OCT 10 1957

RECEIVED

1

10848

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10824

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Kenwood) | | | | c. LENGTH OF STAY IN 1b
25 years | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Kenwood) x2 | | | | d. STREET ADDRESS
5331 Chamberlin Avenue | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
5331 Chamberlin Avenue | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Virginia Middle CULL Last CULL | | | | 4. DATE OF DEATH
Month October Day 11 Year 19 57 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Oct. 6, 1877 | |
| 9. AGE (In years last birthday)
80 yrs. | | IF UNDER 1 YEAR
Months 0 Days 5 Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Never worked | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- - - - - | | 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Judson T. Cull, Sr. | | | | 14. MOTHER'S MAIDEN NAME
Mary Lanahan | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Judson French-Same Item #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic Carcinoma
153X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Colon
DUE TO (c) 1 1/2 yrs.
INTERVAL BETWEEN ONSET AND DEATH
1 1/2 yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from on 10/11 , 19 57 , to 10/13/57 , that I last saw the deceased alive on 10/13/57 , and that death occurred at 9 P. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 1150 Connecticut Ave. N. W. Wash. D. C. DATE SIGNED 10/13/57 | | | | | | | |
| ACTUAL SIGNATURE James A. Kehoe M.D. M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) James A. Kehoe, M. D. | | | | 1150 Connecticut Ave. N. W. Wash. D. C. | | | |
| 22a. BURIAL, CREMATION, REINTERMENT
Cremation | | 22b. DATE THEREOF
10/14/1957 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 22d. LOCATION (City, town, or county) (State)
Prince Georges Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md | | | | 24a. REC'D BY REGISTRAR
DATE 10-16-57 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|----------------------------------|--|
| NAME OF DECEASED
Bellesda (H. Woods) | | MARRIAGE
None | |
| AGE
28 years | | SEX
Male | |
| RESIDENCE
5231 Chamberlin Avenue | | CITY
Baltimore | |
| DATE OF DEATH
Oct. 18, 1957 | | PLACE OF DEATH
Home | |
| CAUSE OF DEATH
Heart Disease | | MANNER OF DEATH
Natural | |
| SIGNATURE OF DECEASED
(None) | | SIGNATURE OF WITNESSES
(None) | |
| SIGNATURE OF PHYSICIAN
(None) | | SIGNATURE OF CORONER
(None) | |
| SIGNATURE OF MINISTER
(None) | | SIGNATURE OF JURY
(None) | |

BUREAU V. S.

OCT 18 1957

RECEIVED

Examination 10/18/57
Robert A. Humphrey-7537
James A. Rohrer, M.D.
1100 Connecticut Ave.
Baltimore, Md.

10849

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XOWHEATON SILVER SPRING</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>12201-BUSHEY DRIVE.</u> | |
| 3. NAME OF DECEASED
(Type or print) First <u>DELLA</u> Middle <u>CURRAN</u> Last <u>CURRAN</u> | | 4. DATE OF DEATH Month <u>OCT</u> Day <u>29</u> Year <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 23, 1887</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>NEBRASKA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>MICHAEL CAVANAUGH</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY MCGRATH.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>FLAINE REYNOLDS</u> Address <u>12201-BUSHEY DR S.S. MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
<u>332x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u>
DUE TO (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>9-4-</u> 1957, to <u>10/29</u> 1957, that I last saw the deceased alive on <u>10/29</u> 1957, and that death occurred at <u>3:30p</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W. C. Shoemaker M.D.</u> | | ADDRESS (Street, city or town, state) <u>8005 Woodbury Dr Silver Spring, Md</u> | |
| PHYSICIAN'S NAME (Type) <u>N.C. SHOEMAKER M.D.</u> | | DATE SIGNED <u>10/29/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>10/30/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Chicago, Ill</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulon</u> ADDRESS <u>3831-Ya Ave NW</u> | | 24a. REC'D BY REGISTRAR <u>CT 51957</u> DATE <u>10/29/57</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 31 1957

RECEIVED

10850

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film 6222 11-8-57 et

Reg. Dist. No. 217

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| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | c. LENGTH OF STAY IN 1b
1 day | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Montg. Co. Gen. Hosp. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Craver Last Dailey | | 4. DATE OF DEATH
Month Oct. Day 27 Year 1957 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/11/92 |
| 9. AGE (In years last birthday)
64 yrs. | | IF UNDER 1 YEAR
Months 64 Days 0 Hours 0 Min. 0 | IF UNDER 24 HRS.
Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Zach. T. Musgrove | | 14. MOTHER'S MAIDEN NAME
Emma Craver | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
10850 | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolism & Infarction
903.0
DUE TO
Fracture of left arm
Conditions, if any, which gave rise to immediate cause (b) 12 days
(c) 12 days
DUE TO
cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell over piece of furniture at home and fractured left arm. | |
| 20c. TIME OF INJURY
Month, Day, Year
12:45 a.m. 10/15/57 | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
home | 20f. (City or town) (County) (State)
Brookville Montg. Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | DATE SIGNED 10/27/57 | |
| EXAMINER'S NAME (Type)
Frank J. Broschart | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
Oct 30/57 | 22c. NAME OF CEMETERY OR CREMATORY
Salon | 22d. LOCATION (City, town, or county) (State)
Brookville Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Roy W. Barber Lexington | | 24a. REC'D BY REGISTRAR
10-31-57 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE
Gertrude Blawie | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---------------------|--|----------------------|--|-----------------------|--|----------------------|--|-----------------------|--|-----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES J. JONES | | 45 | | M | | W | | 11-1-57 | | BALTIMORE, MD. | |
| RESIDENT OF | | CITY OF DEATH | | COUNTY OF DEATH | | STATE OF DEATH | | CITY OF DEATH | | COUNTY OF DEATH | |
| BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | MILITARY SERVICE | | REMARKS | |
| CLERK | | HIGH SCHOOL | | MARRIED | | METHODIST | | NONE | | HEART DISEASE | |
| PREVIOUS ILLNESS | | CAUSE OF DEATH | | MANNER OF DEATH | | TOXICOLOGY | | AUTOPSY | | SIGNATURE OF EXAMINER | |
| NONE | | HEART DISEASE | | NATURAL | | NONE | | NONE | | JAMES J. JONES | |
| DATE OF EXAMINATION | | PLACE OF EXAMINATION | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF EXAMINER | | DATE OF EXAMINATION | |
| 11-1-57 | | BALTIMORE | | JAMES J. JONES | | JAMES J. JONES | | JAMES J. JONES | | 11-1-57 | |

BUREAU V. 2

NOV 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10785

Item 2. See: Birth Cert. et

CERTIFICATE OF DEATH

1082231
Reg. Dist. No.

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|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | |
| c. LENGTH OF STAY IN TB 2 hours 7 min | | | | 17 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | | | d. STREET ADDRESS 7427 Aspen Court | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Infant Boy Damazo | | | | 4. DATE OF DEATH October 14 19 57 | | | |
| 5. SEX Boy | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 14, 1957 | |
| 9. AGE (In years last birthday) 2 | | 10. IF UNDER 1 YEAR Months 2 Days 7 | | 11. IF UNDER 24 HRS. Hours 2 Min. 7 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | |
| 13. FATHER'S NAME Herbert Souza Damazo | | | | 14. MOTHER'S MAIDEN NAME Ila Jane Crabbs | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. Mother's chart | | | |
| 17. INFORMANT Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity - 5 1/2 mo. gestation;
776X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED 10-14-57 | | | | | | | |
| ACTUAL SIGNATURE Emma Hughes M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 10-15-57 | | 22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hosp. Takoma Park, Md. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D. ADDRESS Wash. San. & Hosp. | | | | 24a. REC'D BY REGISTRAR 10/22/57 | | 24b. REGISTRAR'S SIGNATURE J. William Dool | |

2075232XVI

CERTIFICATE OF DEATH

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| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
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10851

CERTIFICATE OF DEATH

Reg. Dist. No.

212

| | | | | | | | |
|---|---------------------------|--|--|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairfax</u> x2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u> | | | | d. STREET ADDRESS <u>1</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>S</u> Last <u>Dawson</u> | | | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>28</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 17 1893</u> 64 yrs. | | 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm labourer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Deignier</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>William T. Dawson</u> | | | | 14. MOTHER'S M maiden name <u>Cora V. Edwards</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>226-36-566</u> | | 17. INFORMANT <u>George Dawson - Harrison Va -</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer, Bronchogenic with metastasis</u>
<u>162X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>October, 1956</u> , to <u>29 Oct</u> , 1957, that I last saw the deceased alive on <u>28 Oct</u> , 1957, and that death occurred at <u>3:30 p.m.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Jordan M. Smith</u> | | | | ADDRESS (Street, city or town, state) <u>Barnesville, Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Jordan M. Smith</u> | | | | DATE SIGNED <u>28 Oct 57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/30/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Heesburg</u> | | 22d. LOCATION (City, town, or county) <u>Va</u> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Barnesville, Md</u> | | | | 24a. REC'D BY REGISTRAR <u>10/29/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE STATE OF

DATE OF DEATH

AGE

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

INTERMEDIATE CAUSE

PREEXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF EXAMINATION

PLACE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

NAME OF PHYSICIAN

ADDRESS OF PHYSICIAN

CITY OF PHYSICIAN

STATE OF PHYSICIAN

BUREAU X. B.

OCT 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10829

10852

CERTIFICATE OF DEATH

Reg. Dist. No. 217

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | c. LENGTH OF STAY IN 1b
3 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
x2 Gaithersburg | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Montgomery Co. General Hospital, Inc. | | d. STREET ADDRESS
Rt. #1 | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First John Middle T. Last Demar | | 4. DATE OF DEATH
Month October Day 6 Year 57 | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/13/90 |
| 9. AGE (In years last birthday)
67 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Labor | | 10b. KIND OF BUSINESS OR INDUSTRY
Farm | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Hildra Demar | |
| 14. MOTHER'S MAIDEN NAME
Sarah M. Bowie | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes WWI | |
| 16. SOCIAL SECURITY NO.
217 30 0504 | | 17. INFORMANT
Hospital Record | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease - Malignant phase
DUE TO 443x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Oct-3 , 19 57 , to Oct-6 , 19 57 , that I last saw the deceased alive on Oct-6 , 19 57 , and that death occurred at 9:30P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Jack Schumacher M.D. | | ADDRESS (Street, city or town, state) 26 N. Summitt Ave., Gaithersburg, Md.
DATE SIGNED 10-7-57 | |
| PHYSICIAN'S NAME (Type) Jack Schumacher, M. D. | | 26 N. Summitt Ave., Gaithersburg, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Oct. 9 1957 | 22c. NAME OF CEMETERY OR CREMATORY
Brook Grove | 22d. LOCATION (City, town, or county) (State)
Laytonsville Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Roy W Barber | | ADDRESS
Laytonsville, Md | |
| 24a. REC'D BY REGISTRAR
10-8-57 | | 24b. REGISTRAR'S SIGNATURE
Gertrude B. Lawley | |

CERTIFICATE OF DEATH

1083073

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u> | | | | d. STREET ADDRESS <u>2950 Legation St., N.W.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Rena</u> First <u>Newhouse</u> Middle <u>Dessez</u> Last | | | | 4. DATE OF DEATH <u>10 - 24</u> 19 <u>57</u> Month Day Year | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-24-98</u> | |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Robert Bruce</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Jenny Johnson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>Washington Sanitarium and Hospital records</u> | | | |
| 17. INFORMANT <u>Washington Sanitarium and Hospital records</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute intestinal obstruction</u>
DUE TO <u>157X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Carcinomatosis</u>
DUE TO <u>possibly metastatic from pancreas</u> .
(c) <u>2 months</u>
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>9-1-57</u> , 19 <u>57</u> , to <u>10-24-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-24-57</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> P.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>7600 Carroll Ave, Takoma Park, Md</u> DATE SIGNED <u>10-25-57</u>
ACTUAL SIGNATURE <u>Arthur E Coyne</u> M.D.
PHYSICIAN'S NAME (Type) <u>ARTHUR E COYNE</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/28/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paulus</u> ADDRESS <u>1756 Pa Ave N.W.</u> | | | | 24. REC'D BY REGISTRAR <u>10-28-57</u> DATE | | 25. REGISTRAR'S SIGNATURE <u>John H. Hodge</u> | |

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *Jan 15 1910*

5. PLACE OF BIRTH: *John Doe, Md.*

6. OCCUPATION: *Farmer*

7. CAUSE OF DEATH: *Heart Disease*

8. DATE OF DEATH: *Oct 28 1957*

9. PLACE OF DEATH: *John Doe, Md.*

10. SIGNATURE OF PHYSICIAN: *John Doe, M.D.*

11. SIGNATURE OF REGISTRAR: *John Doe*

12. SIGNATURE OF WITNESSES: *John Doe, John Doe*

BUREAU V. 2

OCT 28 1957

RECEIVED

THIS IS A PUBLIC RECORD. IT IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE PUBLIC RECORDS OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE PUBLIC RECORDS OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE PUBLIC RECORDS OF THE STATE OF MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10831

10853

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Springs</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>56 Silver Springs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>624 Mississippi Ave</u> | | | | d. STREET ADDRESS
<u>624 Mississippi Ave</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Charles Arthur Devers</u> | | | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>25</u> Year <u>1957</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb 11 1866</u> | 9. AGE (In years last birthday)
<u>91</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Brick Layer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Washington DC</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>?</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
<u>No</u> | | 17. INFORMANT
<u>Herbert A Devers</u> Address <u>3304 Fayette Rd. Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.0 Congestive heart failure</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) <u>Generalized arteriosclerosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 d</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. Month, Day, Year
<u>19</u> | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct. 22</u> , 1957, to <u>Oct 25</u> , 1957, that I last saw the deceased alive on <u>Oct 24</u> , 1957, and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>M. F. Ottman</u> | | | | ADDRESS (Street, city or town, state) <u>401 Kennedy St NW Wash DC</u> | | | |
| PHYSICIAN'S NAME (Type) <u>M. F. OTTMAN</u> | | | | DATE SIGNED <u>Oct 25, 1957</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10-28-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rock Creek Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Washington DC</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Deaf Funeral Home</u> | | | | ADDRESS
<u>4812 Ga Ave NW</u> | | 24a. REC'D BY REGISTRAR
DATE <u>28 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Frances Potter</u> | | | |

NOV 28 1957

BUREAU V. 5

RECEIVED

10854

CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Potomac | | c. LENGTH OF STAY IN 1b
Rockville 26 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Ropine Rest Home | | d. STREET ADDRESS
1017 Maple Ave. | |
| 3. NAME OF DECEASED (Type or print) JOSEPH J. DEVINE | | 4. DATE OF DEATH
Month October Day 22 Year 1957 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/11/78 |
| 9. AGE (In years last birthday)
79 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sexton | | 10b. KIND OF BUSINESS OR INDUSTRY
Catholic Church | |
| 11. BIRTHPLACE (State or foreign country)
New York City | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
John Devine | | 14. MOTHER'S MAIDEN NAME
Catherine Carmady | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
579-48-6788 | |
| 17. INFORMANT
Mrs Harold R. Drumm-Item#2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cerebral ischemia
332x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral thrombosis
DUE TO (c) cerebral arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH
29 hrs
2 wk
Indef |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
gen. arteriosclerosis | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Jan 2, 1952 , to Oct 21, 1957 , that I last saw the deceased alive on 10/22/57 , and that death occurred at 1:30 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Rockville, Md DATE SIGNED 10/23/57 | | | |
| ACTUAL SIGNATURE Stephen N. Jones M.D. Robert A. Pumphrey | | | |
| PHYSICIAN'S NAME (Type) Stephen N. Jones -Rockville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10/25/57 | 22c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | 22d. LOCATION (City, town, or county) (State)
Aspen Hill, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-Bethesda, Md. | | 24a. REC'D BY REGISTRAR
DATE 10-24-57 | 24b. REGISTRAR'S SIGNATURE
Bernie M. Thompson |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|----------------------------|--|---------------------------------|--|
| DATE OF DEATH
10/28/57 | | PLACE OF DEATH
Home | |
| DECEASED
JOHN DEAN | | AGE
71 | |
| SEX
Male | | RACE
White | |
| BIRTH
1886 | | EDUCATION
High School | |
| OCCUPATION
None | | MARRIAGE
Married | |
| RELIGION
Catholic | | BAPTISM
Yes | |
| US CITIZENSHIP
Yes | | MILITARY SERVICE
None | |
| PREVIOUS ILLNESS
None | | CAUSE OF DEATH
Heart Disease | |
| MANNER OF DEATH
Natural | | CERTIFICATE NO.
100-100000 | |
| DATE OF DEATH
10/28/57 | | PLACE OF DEATH
Home | |
| DECEASED
JOHN DEAN | | AGE
71 | |
| SEX
Male | | RACE
White | |
| BIRTH
1886 | | EDUCATION
High School | |
| OCCUPATION
None | | MARRIAGE
Married | |
| RELIGION
Catholic | | BAPTISM
Yes | |
| US CITIZENSHIP
Yes | | MILITARY SERVICE
None | |
| PREVIOUS ILLNESS
None | | CAUSE OF DEATH
Heart Disease | |
| MANNER OF DEATH
Natural | | CERTIFICATE NO.
100-100000 | |

RECEIVED
OCT 28 1957
BUREAU V. 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10833

10855

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 218

| | | | | | | | |
|---|---------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Gaithersburg R - 1</u> | | c. LENGTH OF STAY IN 1b
<u>life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X2 Gaithersburg R - 1</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Emory Grove</u> | | | | d. STREET ADDRESS
<u>1 Emory Grove</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Myra</u> Middle <u>Jean</u> Last <u>Dobson</u> | | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>6</u> Year <u>57</u> | | | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>6/10/1957</u> | | 9. AGE (In years last birthday)
<u>XXX</u> yrs. | IF UNDER 1 YEAR
Months <u>3</u> Days <u>28</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>James Dobson</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Jean Mary Murray</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>(If yes, give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mother</u> Address <u>Same as Item 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia</u>
<u>475X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Upper Respiratory Infection</u>
(c) <u>stopping the underlying cause last.</u> DUE TO
INTERVAL BETWEEN ONSET AND DEATH
<u>Found dead in bed.</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour <u>o. m.</u> <u>19</u> Month, Day, Year | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/6/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10/9/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Arlington, Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert L. Snowden</u> | | | | ADDRESS
<u>Rockville, Md.</u> | | 24d. REC'D BY REGISTRAR
DATE <u>10/10/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Alverda Cooke</u> | | | |

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

10834-73

10787

| | | | | | | | |
|---|----------------------------------|---|-----------------------------------|--|---|---|------------------|
| 1. PLACE OF DEATH
o. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Md</i> b. COUNTY <i>Montgomery</i> P.C. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Takoma Park</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Hyattsville</i> 1615.2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Washington Sanitarium & Hospital</i> | | | | d. STREET ADDRESS
<i>6208 42nd Ave.</i> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>Henry</i> Middle <i>Winford</i> Last <i>Donoghue</i> | | | | 4. DATE OF DEATH
Month <i>10</i> Day <i>-6-</i> Year <i>1957</i> | | | |
| 5. SEX
<i>M</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>6-7-87</i> | 9. AGE (In years last birthday)
<i>70</i> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Electrician (Retired)</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Naval Gun Factory</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Mass.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Daniel W. Donoghue</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>KATHRYN McAllister</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>no</i> | | 16. SOCIAL SECURITY NO.
<i>none</i> | | 17. INFORMANT
<i>Washington Sanitarium & Hospital Records</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary hemorrhage</i>
DUE TO <i>congestive heart failure</i>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Hypertensive cardiovascular disease</i>
DUE TO (c) <i>Intestinal hemorrhage - acute colitis</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>3 days</i>
<i>1 mo</i>
<i>years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>Intestinal hemorrhage - acute colitis</i> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>October 1, 1957</i> , to <i>October 6, 1957</i> , that I last saw the deceased alive on <i>October 5, 1957</i> , and that death occurred at <i>6:50 AM</i> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<i>Boris Rabkin</i> M.D. <i>1019 University, Bethesda, Md.</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>ENTOMBMENT</i> | | | | 22b. DATE THEREOF
<i>10/9/57</i> | | 22c. NAME OF CEMETERY OR CREMATORY
<i>Fr. Lincoln Cemetery</i> | |
| 22d. LOCATION (City, town, or county) (State)
<i>Prince George County, Md.</i> | | | | 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Robert E. Humphrey</i> ADDRESS
<i>Silver Spring, Maryland</i> | | | |
| 24a. REC'D BY REGISTRAR
<i>OCT 8 1957</i> | | | | 24b. REGISTRAR'S SIGNATURE
<i>J. Nelson</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. PLACE OF BIRTH | | 5. DATE OF BIRTH | | 6. PLACE OF DEATH | |
| 7. OCCUPATION | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | |
| 10. DATE OF DEATH | | 11. TIME OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF DECEASED | |

BUREAU V. S.

OCT 8 1957

RECEIVED

10788

CERTIFICATE OF DEATH

10835

Reg. Dist. No.

773

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u> | | d. STREET ADDRESS <u>11612 Noyes Dr.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Gertrude</u> Last <u>Drake</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-5-79</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horsewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>England</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> | |
| 13. FATHER'S NAME <u>Edmond Salmon</u> | | 14. MOTHER'S MARDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Chart</u> | | Address <u></u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Embolized Arteriosclerosis</u>
DUE TO
(c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u></u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>Oct 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 13</u> , 19 <u>57</u> , and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Harry N. Carlton</u> | | ADDRESS (Street, city or town, state) <u>1522 Flora Ct. Silver Spring, Md</u> | |
| PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u> | | DATE SIGNED <u>Oct 13/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u> | 22b. DATE THEREOF <u>10/15/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Bishopville Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Knox County, Tennessee</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner & Humphrey</u> | | ADDRESS <u>Silver Spring, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>OCT 15 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dade</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---------------------|--|------------------------|--|
| PLACE OF DEATH | | MANNER OF DEATH | |
| HOME | | NATURAL | |
| CITY OF BALTIMORE | | SUICIDE | |
| COUNTY OF BALTIMORE | | HOMICIDE | |
| STATE OF MARYLAND | | OTHER | |
| DECEASED'S NAME | | AGE | |
| JOHN J. ROSS | | 65 | |
| SEX | | RACE | |
| MALE | | WHITE | |
| DATE OF DEATH | | TIME OF DEATH | |
| OCTOBER 15, 1967 | | 10:30 AM | |
| PLACE OF BIRTH | | EDUCATION | |
| BALTIMORE, MARYLAND | | HIGH SCHOOL | |
| OCCUPATION | | CAUSE OF DEATH | |
| LABORER | | HEART DISEASE | |
| PREVIOUS ILLNESS | | IMMEDIATE CAUSE | |
| NONE | | CORONARY THROMBOSIS | |
| MEDICAL ATTENDANCE | | PATHOLOGICAL FINDINGS | |
| YES | | HEART ENLARGED | |
| NAME OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | |
| DR. J. J. ROSS | | [Signature] | |
| DATE OF EXAMINATION | | SIGNATURE OF REGISTRAR | |
| OCTOBER 15, 1967 | | [Signature] | |

BUREAU V. S.

OCT 15 - 1967

RECEIVED

10856

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|---------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | | | d. STREET ADDRESS <u>5706 Frederick Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Janet</u> Middle <u>Mary</u> Last <u>Duckworth</u> | | | | 4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8/16/01</u> | | 9. AGE (In years last birthday) <u>56</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>England</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>England</u> ✓ | |
| 13. FATHER'S NAME <u>unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Hospt. Record</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
<u>260x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetic Coma</u>
DUE TO (c) <u>Diabetes mellitus</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 min.</u>
<u>10 hours</u>
<u>unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Occlusion</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>10/14</u> , 19 <u>57</u> , to <u>10/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/14</u> , 19 <u>57</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Frank Y. Jagers Jr.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave</u> DATE SIGNED <u>10/14/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>FRANK Y. JAGGERS-JR</u> | | | | <u>Cherry Chase 15 Ind.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/16/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | | | ADDRESS <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>DATE 10-16-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Bernard M. Thompson</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED
[Illegible] | | 2. SEX
[Illegible] | | 3. AGE
[Illegible] | |
| 4. PLACE OF BIRTH
[Illegible] | | 5. DATE OF BIRTH
[Illegible] | | 6. PLACE OF DEATH
[Illegible] | |
| 7. OCCUPATION
[Illegible] | | 8. CAUSE OF DEATH
[Illegible] | | 9. MANNER OF DEATH
[Illegible] | |
| 10. SIGNATURE OF PHYSICIAN
[Illegible] | | 11. SIGNATURE OF CORONER
[Illegible] | | 12. SIGNATURE OF DECEASED
[Illegible] | |
| 13. SIGNATURE OF WITNESS
[Illegible] | | 14. SIGNATURE OF DECEASED
[Illegible] | | 15. SIGNATURE OF DECEASED
[Illegible] | |
| 16. SIGNATURE OF DECEASED
[Illegible] | | 17. SIGNATURE OF DECEASED
[Illegible] | | 18. SIGNATURE OF DECEASED
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| 19. SIGNATURE OF DECEASED
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| 22. SIGNATURE OF DECEASED
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| 31. SIGNATURE OF DECEASED
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| 34. SIGNATURE OF DECEASED
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| 70. SIGNATURE OF DECEASED
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| 82. SIGNATURE OF DECEASED
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| 85. SIGNATURE OF DECEASED
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| 88. SIGNATURE OF DECEASED
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| 91. SIGNATURE OF DECEASED
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| 94. SIGNATURE OF DECEASED
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| 97. SIGNATURE OF DECEASED
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| 100. SIGNATURE OF DECEASED
[Illegible] | | 101. SIGNATURE OF DECEASED
[Illegible] | | 102. SIGNATURE OF DECEASED
[Illegible] | |

BUREAU V. S.

OCT 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10857
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10837
213
Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WHEATON CITY</u> | c. LENGTH OF STAY IN 1b
<u>1 yr.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WHEATON CITY</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>4407 HALLET ST.</u> | | d. STREET ADDRESS
<u>4407 HALLET ST.</u> | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>ROSSER</u> Middle <u>JAMES</u> Last <u>DUNGAN</u> | | 4. DATE OF DEATH
Month <u>OCT.</u> Day <u>5</u> Year <u>1957</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 4, 1907</u> |
| 9. AGE (In years last birthday) <u>50</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>SHEET METAL</u> | 11. BIRTHPLACE (State or foreign country)
<u>HYACINTH, VA.</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Calis Dungan</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Agnes Burgess</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> | |
| 16. SOCIAL SECURITY NO.
<u>579-10-5010</u> | | 17. INFORMANT
<u>Virgin V. Dungan</u> Address <u>4407-Hallet St. Wheaton City, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>162X</u> DUE TO <u>Breast Cancer</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Interval between onset and death 6 months</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u> |
| MEDICAL CERTIFICATION
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 15</u> , 19 <u>56</u> to <u>Oct 4</u> , 19 <u>57</u> , that I lost saw the deceased alive on <u>Oct 4</u> , 19 <u>57</u> , and that death occurred at <u>4</u> A. M. from the causes and on the date stated above.
ACTUAL SIGNATURE <u>Charles M. Weber</u> M.D. <u>12600-Parkland Dr. Rockville Md.</u>
PHYSICIAN'S NAME (Type) <u>CHARLES M. WEBER</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>10-6-57</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Henderson Church Em. Hyacinth, Virginia</u> | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. W. Chambers Jr. 517-11th St. S.E.</u> | | 24a. REC'D BY REGISTRAR
<u>OCT 9 1957</u> | 24b. REGISTRAR'S SIGNATURE
<u>Lawell Hagtopp</u> |

BUREAU V.

OCT 9 1957

RECEIVED

10838

10789

CERTIFICATE OF DEATH

Reg. Dist. No.

723

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b
<u>2 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Washington San + Hospital</u> | | | | d. STREET ADDRESS
<u>1406 Quaint Acres Dr.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Edith</u> Middle <u>(NMN)</u> Last <u>DUNLOP</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>2</u> Year <u>1957</u> | | | | | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-22-79</u> | 9. AGE (In years last birthday)
<u>78</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Mass.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Peter Lyall</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Severn</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>None</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
<u>Daughter</u> | | Address
<u>Same as patient</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Melastotic Carcinoma</u>
<u>174X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of uterus</u>
DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. | | Month, Day, Year
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 19, 1957</u> to <u>Oct. 2, 1957</u> , that I last saw the deceased alive on <u>Oct 2, 1957</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Marion Bankhead</u> M.D. | | | | ADDRESS (Street, city or town, state)
<u>9241 Col. Blvd.</u> | | | |
| DATE SIGNED
<u>10/2/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type)
<u>J. Marion Bankhead Silver Spring, Md</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Oct. 5, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Fort Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Prince George's County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Walter E. Humphrey</u> | | | | ADDRESS
<u>Silver Spring, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 4 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>J. William Addy</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4 OCT 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG222 11-5-57 et

CERTIFICATE OF DEATH

10839

Reg. Dist. No.

216

10859

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>D. C.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <u>47X-3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> | | d. STREET ADDRESS <u>1414A HALF ST.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>JAMES WALTER DYSON</u> | | 4. DATE OF DEATH Month Day Year
<u>Oct 19 1957</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>NEGRO</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>DEC 27-1893</u> |
| 9. AGE (In years lost birthday) <u>63</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min.
<u>63</u> <u>11</u> <u>19</u> <u>57</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>FOREMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>ROOFING CO.</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>JOHN DYSON</u> | | 14. MOTHER'S MAIDEN NAME
<u>EDITH CLARK</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>YES</u> (If yes, give war or dates of service)
<u>Aug-1918 - Apr-1919</u> | | 16. SOCIAL SECURITY NO.
<u>NO</u> | |
| 17. INFORMANT
<u>CLARA IRENE DYSON - SAME</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac tamponade</u>
DUE TO <u>Ruptured dissecting aneurysm</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 days</u>
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
<u>19</u> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct 14</u> , 19 <u>57</u> , to <u>Oct 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 18</u> , 19 <u>57</u> , and that death occurred at <u>6:40A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Allen J. O'Neill</u> | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>864 Old Georgetown Rd, Bethesda Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u> | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify)
<u>13-24-57</u> | 22b. DATE THEREOF
<u>10/24/57</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National</u> | 22d. LOCATION (City, town, or county) (State)
<u>Arlington Va</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Burnes & Matthews</u> | | 24a. REC'D BY REGISTRAR
<u>3619-14st</u>
<u>Wash, DC</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Bessie Thompson</u> | | | |

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

BUREAU V. 51

1 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10840

10859

CERTIFICATE OF DEATH

Reg. Dist. No. 217

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | | | c. LENGTH OF STAY IN 1b
6 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Montgomery Co. General Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First James Middle Edmond Last Eckloff | | | | 4. DATE OF DEATH
Month October Day 30 Year 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/22/74 | |
| 9. AGE (In years last birthday)
82 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired-Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Washington D. C. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Adolphus Eckloff | | | | 14. MOTHER'S MAIDEN NAME
Sarah Ridgeway | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) [If yes, give war or dates of service] | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT
Hospital Record | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hyperpyrexia
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Cerebrovascular Accident
DUE TO (c) Hypertensive Cardiovascular Disease
INTERVAL BETWEEN ONSET AND DEATH
2 days
7 days
yo | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. g. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 10/24 , 19 57 , to 10/30 , 19 57 , that I last saw the deceased alive on 10/30 , 19 57 , and that death occurred at 12:10 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE C. H. Ligon M.D. | | | | DATE SIGNED 10/30/57 | | | |
| PHYSICIAN'S NAME (Type) C. H. Ligon, M. D. | | | | Sandy Spring, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/2/57 | | 22c. NAME OF CEMETERY OR CREMATORY
St. John's Church Cemt. | | 22d. LOCATION (City, town, or county) (State)
Olney, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph F. Birchbina | | | | ADDRESS
3034 N. St., N.W., D.C. | | 24a. REC'D BY REGISTRAR
E. Lawler | |
| 24b. REGISTRAR'S SIGNATURE | | | | | | | |

CT

RECEIVED

BUREAU V. B.

1957 3 AQH

G. H. Mason, M. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10841

CERTIFICATE OF DEATH

Reg. Dist. No.

773

10790

| | | | | | | | |
|--|-------------------------------|--|---------------------------------|---|-----------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>Silver Spring 56</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | | | d. STREET ADDRESS <u>9512 Carolina Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Charles Gilbert Eisenhart</u> | | | | 4. DATE OF DEATH <u>Oct 6 1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-3-88</u> | 9. AGE (In years last birthday) <u>69</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Butcher-Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pa</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | | | | | | | |
| 13. FATHER'S NAME <u>Gabriel Eisenhart</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Swinford</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | |
| 17. INFORMANT <u>Hospital Records.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchial Asthma</u>
<u>241X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Emphysema</u>
DUE TO (c) <u>—</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 years</u>
<u>10 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb 1, 1957</u> to <u>Oct 6, 1957</u> that I last saw the deceased alive on <u>Oct 6, 1957</u> , and that death occurred at <u>4A</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John J. Curry</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>10620 Georgiadene</u> DATE SIGNED <u>10/6/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Silver Spring, Md</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>10-9-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK</u> | | 22d. LOCATION (City, town, or county) (State) <u>WASHINGTON DC</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> ADDRESS <u>4812 Ga Ave NW Wash DC</u> | | | | 24a. REC'D BY REGISTRAR <u>—</u> DATE <u>OCT 9 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>—</u> | |

CERTIFICATE OF DEATH

Reg. Dist. No.

773

10791

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>D.C.</i> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washi</i> 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. San. Hosp.</i> | | | | d. STREET ADDRESS <i>3720 Upton N.W.</i> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>CLARK</i> Last <i>Mrs. Farquhar</i> | | | | 4. DATE OF DEATH Month <i>Oct</i> Day <i>4</i> Year <i>1957</i> | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Mar 15 1873</i> | |
| 9. AGE (In years last birthday) <i>84</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 11. BIRTHPLACE (State or foreign country) <i>N.Y.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Benjamin Charles</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Sarah Ellen Thorn</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>Wash. Home of Incurable Records Wash D.C.</i> | | | |
| 17. INFORMATION | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>447X</i> DUE TO <i>Paralytic Ileus</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Gen. Arteriosclerosis with Hypertension</i> (c) <i>Chl. Uremia</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
<i>1942</i>
<i>1953.</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <i>June 10, 1944</i> to <i>Oct 4, 1957</i> , that I last saw the deceased alive on <i>Oct 4, 1957</i> , and that death occurred at <i>5:30 P.</i> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Edward J. Moore</i> M.D. | | | | ADDRESS (Street, city or town, state) <i>7030 Carroll Ave. Takoma Park Md.</i> DATE SIGNED <i>10/5/57</i> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | | 22b. DATE THEREOF <i>10/8/57</i> | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) <i>Warwick, New York</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Jones Co</i> ADDRESS <i>194 St. N.W.</i> | | | | 24. REC'D BY REGISTRAR DATE <i>8 1957</i> | | 24b. REGISTRAR'S SIGNATURE <i>J. Wilson</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 8 1957

BUREAU V. S.

| | | | |
|----------------------------|--|-------------------------------------|--|
| STATE OF MARYLAND | | DEPARTMENT OF HEALTH-BALTIMORE, MD. | |
| CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED | | 2. SEX | |
| 3. AGE | | 4. RACE | |
| 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. PLACE OF DEATH | |
| 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | |
| 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
| 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF DECEASED | |
| 15. SIGNATURE OF DECEASED | | 16. SIGNATURE OF DECEASED | |
| 17. SIGNATURE OF DECEASED | | 18. SIGNATURE OF DECEASED | |
| 19. SIGNATURE OF DECEASED | | 20. SIGNATURE OF DECEASED | |
| 21. SIGNATURE OF DECEASED | | 22. SIGNATURE OF DECEASED | |
| 23. SIGNATURE OF DECEASED | | 24. SIGNATURE OF DECEASED | |
| 25. SIGNATURE OF DECEASED | | 26. SIGNATURE OF DECEASED | |
| 27. SIGNATURE OF DECEASED | | 28. SIGNATURE OF DECEASED | |
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| 91. SIGNATURE OF DECEASED | | 92. SIGNATURE OF DECEASED | |
| 93. SIGNATURE OF DECEASED | | 94. SIGNATURE OF DECEASED | |
| 95. SIGNATURE OF DECEASED | | 96. SIGNATURE OF DECEASED | |
| 97. SIGNATURE OF DECEASED | | 98. SIGNATURE OF DECEASED | |
| 99. SIGNATURE OF DECEASED | | 100. SIGNATURE OF DECEASED | |

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

10792

Items 3/8, 9, 14 Film G222 11-25-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

10843 23

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | | | c. LENGTH OF STAY IN 1b
5 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
36 Philadelphia Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
CHARLES W. FARRER | | | | 4. DATE OF DEATH
Month October Day 9 Year 1957 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 25, 1880 AGE (In years last birthday) 77 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
(Ret) Plastering Contr. | | 10b. KIND OF BUSINESS OR INDUSTRY
Gen. Bldg. Trades | | 11. BIRTHPLACE (State or foreign country)
England. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Septemus Farrer | | | | 14. MOTHER'S MAIDEN NAME
Eliza Edwards | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | 16. SOCIAL SECURITY NO.
<input type="checkbox"/> | | 17. INFORMANT
Gwendoline Padgett, 36 Philadelphia Avenue, | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Pulmonary Edema
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Heart Disease DUE TO
(c) Hypertension | | | | INTERVAL BETWEEN ONSET AND DEATH
7 days
5 yrs.
10 yrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from June 30, 1957 to 1957 , that I last saw the deceased alive on 1957 , and that death occurred at 4:53 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Francis X. Richardson M.D. | | | | ADDRESS (Street, city or town, state) 7717 Clarks Ave. Md | | | |
| DATE SIGNED 10/11/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) FRANCIS X. RICHARDSON | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Cremation | | Oct. 11, 1957 | | Ft. Lincoln Crematory | | Bladensburg Road Ar.D. CLINE Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Stollers | | | | ADDRESS Takoma Park, D.C. | | 24a. REC'D BY REGISTRAR | |
| | | | | 254 Carroll St. N. W. | | 24b. REGISTRAR'S SIGNATURE J. Wilson Dool | |

RECEIVED

OCT 14 1957

BUREAU V. 2

| | |
|---|--|
| MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12 | |
| CERTIFICATE OF DEATH | |
| NAME OF DECEASED | |
| DATE OF DEATH | |
| PLACE OF DEATH | |
| CAUSE OF DEATH | |
| MANNER OF DEATH | |
| AGE | |
| SEX | |
| RACE | |
| BIRTH DATE | |
| BIRTH PLACE | |
| EDUCATION | |
| OCCUPATION | |
| MARRIAGE | |
| PREVIOUS ILLNESS | |
| SIGNS AND SYMPTOMS | |
| TREATMENT | |
| HISTORY | |
| FAMILY HISTORY | |
| SOCIAL HISTORY | |
| PHYSICAL EXAMINATION | |
| LABORATORY EXAMINATIONS | |
| PATHOLOGICAL FINDINGS | |
| DIAGNOSIS | |
| PROGNOSIS | |
| TREATMENT | |
| FOLLOW-UP | |
| SIGNATURE OF PHYSICIAN | |
| SIGNATURE OF REGISTRAR | |
| DATE OF REGISTRATION | |
| PLACE OF REGISTRATION | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10844

10793

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | | | | |
|---|--|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg. | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | | c. LENGTH OF STAY IN Tb
42 yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
17 Takoma Park | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7400 Baltimore Ave. | | | | d. STREET ADDRESS
7400 Baltimore Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First Belinda Middle Shelton Last Finn | | | | 4. DATE OF DEATH Oct. 22, 1957 Month Oct. Day 22 Year 1957 | | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7/15/1883 | | |
| 9. AGE (in years by birthday)
74 yrs. | | IF UNDER 1 YEAR
Months 74 Days 0 | | IF UNDER 24 HRS.
Hours 0 Min. 0 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
at home | | 11. BIRTHPLACE (State or foreign country)
Fredericksburg, Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Ralph T. Shelton | | | | 14. MOTHER'S MAIDEN NAME
Jane Limerick | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
[blank] | | 17. INFORMANT
Mrs. Jane Francis Shugrue, Bethesda, Md. Address 9212 Chanute Dr. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (b) 420.1
(c), stating the underlying cause last. DUE TO (c) [blank] | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) [blank] | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/22/57 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct. 25, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY
George Washington Cemetery | | 22d. LOCATION (City, town, or county) (State)
Prince Geo. Co. Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. Critter Walters, 254 Carroll St NW, D.C. | | | | 24a. REC'D BY REGISTRAR
10/24/57 | | 24b. REGISTRAR'S SIGNATURE
Wilma DeWitt | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be filed for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.



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| | | | | | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|---|--|--|--|---|--|---|--|
| 18 Film 222 11-5-57 am | | | | | | | | | | | | | | | |
| 10860 | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | | c. LENGTH OF STAY IN 1b
6 months | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1303 Forest Glen Road | | | | | | | | d. STREET ADDRESS
1303 Forest Glen Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First GAY Middle DAVIS Last FISHER | | | | 4. DATE OF DEATH
Month OCTOBER Day 31 Year 1957 | | | | | | | | | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
7/6/26 | | 9. AGE (In years last birthday)
31 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOMEMAKER | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | | | 11. BIRTHPLACE (State or foreign country)
Johnstown, Ohio | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Merton O'Dell Davis | | | | | | 14. MOTHER'S MAIDEN NAME
Ludell Benton | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | | | 16. SOCIAL SECURITY NO.
226-26-3818 | | | | 17. INFORMANT
Police record | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia due to carbon monoxide poisoning
890.0 DUE TO (b) (Accidental)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chimney stopped up due to several dead birds and nest in chimney | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>
CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Found dead in home filled with gas and soot | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour ? a. m. ? p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town)
Silver Spring, Montgomery Co, | | (County)
(Md.) | | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Frank J. Broschart</i> | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | DATE SIGNED
10/31/57 | | | |
| EXAMINER'S NAME (Type)
FRANK J. BROSCHART | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 22b. DATE THEREOF
11/4/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Nat'l. Mem. Park Cemetery | | | | 22d. LOCATION (City, town, or county) (State)
Falls Church, Virginia | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Warner E. Humphrey</i> | | | | | | ADDRESS
Silver Spring, Md. | | | | 24a. REC'D BY REGISTRAR
NOV 1 1957 | | 24b. REGISTRAR'S SIGNATURE
<i>Frances Patter</i> | | | |

THE STATE
HEALTH DEPT.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOV 4 1965

BUREAU N. 2

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

| Item 18 Film 222 11-15-57 | | | | | | | | | | 10861 | | 10846
214 | | |
|--|--|----------------------------------|--|---|--|-----------------------------------|--|---|--|---|--|--|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | Reg. Dist. No. | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY | | | | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | | c. LENGTH OF STAY IN 1b
6 months | | | | |
| 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND | | | | | b. COUNTY MONTGOMERY | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1303 FOREST GLEN ROAD | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | d. STREET ADDRESS
1303 FOREST GLEN ROAD | | | | |
| 3. NAME OF DECEASED
(Type or print)
First GEORGE Middle WILLIAM Last FISHER, JR. | | | | | 4. DATE OF DEATH
Month OCTOBER Day 31 Year 19 57 | | | | | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4/4/22 | | 9. AGE (In years last birthday)
35 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Accountant | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Gov't. | | | | | 11. BIRTHPLACE (State or foreign country)
WASHINGTON, D.C. | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | 13. FATHER'S NAME
George William Fisher | | | | | 14. MOTHER'S MAIDEN NAME
Mary Elizabeth Curran | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | | 16. SOCIAL SECURITY NO.
WW #2 | | | | | 17. INFORMANT
Police record | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia due to carbon monoxide poisoning (Accidental)
890.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
 | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chimney stopped up due to several dead birds and nest in chimney | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>
CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Found dead in home filled with gas and soot | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour ? o. m. ? p. m. 19 | | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | | | |
| 20f. (City or town)
Silver Spring, Mont. Co., Md. | | | | | 20g. (County)
 | | | | | 20h. (State)
 | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | DATE SIGNED 10/31/57 | | | | |
| EXAMINER'S NAME (Type) FRANK J. BROSCART | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | | 22b. DATE THEREOF
11/4/57 | | | | | 22c. NAME OF CEMETERY OR CREMATORY
Nat'l. Mem. Park Cemetery | | | | |
| 22d. LOCATION (City, town, or county)
Falls Church, Virginia | | | | | 22e. REC'D BY REGISTRAR
NOV 4 1957 | | | | | 22f. REGISTRAR'S SIGNATURE
Francis Patten | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Warner E. Rumphey | | | | | | | | | | | | | | |
| ADDRESS
Silver Spring, Maryland | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

15

2

RECEIVED

NOV 4 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

VS. A15ME(5)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 10847 |
|--|--|-----------------------------------|--|--|--|----------------------------------|---|---|--|----------------------------------|
| Item 18 Film 222 11-15-57 and 10862 | | | | | | | | | | 214 |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
c. LENGTH OF STAY IN lb 6 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1303 FOREST GLEN ROAD | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
d. STREET ADDRESS 1303 FOREST GLEN ROAD
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First MARK Middle ANDREW Last FISHER | | | | | 4. DATE OF DEATH
Month OCT. Day 31 Year 19 57 | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/13/51 | | 9. AGE (In years last birthday) 5 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Bethesda, Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME GEORGE WILLIAM FISHER, JR. | | | | | 14. MOTHER'S MAIDEN NAME GAY DAVIS FISHER | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Police records | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia due to carbon monoxide poisoning (Accidental)
890.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chimney stopped up due to several dead birds and nest in chimney | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Found dead in home filled with gas and soot | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. ? p. m. ? 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) Silver Spring, Mont. Co., Md. (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | DATE SIGNED |
| EXAMINER'S NAME (Type) FRANK J. BROSCHART | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | 10/31/57 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/4/57 | | 22c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park Cemetery | | | 22d. LOCATION (City, town, or county) Falls Church, Virginia (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i> ADDRESS Silver Spring, Md. | | | | | 24a. REC'D BY REGISTRAR NOV 4 1957 | | 24b. REGISTRAR'S SIGNATURE <i>Frances Pittery</i> | | | |

RECEIVED

NOV 4 1957

BUREAU V. S.

Form with multiple sections and fields, mostly illegible due to heavy bleed-through from the reverse side. Visible text includes "MEDICAL EXAMINER'S CERTIFICATE OF DEATH" and "MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18".

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10848/274

Reg. Dist. No.

10863

| | | | | | | | |
|---|----------------------------------|--|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | c. LENGTH OF STAY IN 1b
6 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING ✓ | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1303 Forest Glen Road | | | | d. STREET ADDRESS
1303 Forest Glen Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MICHAEL Middle ANTHONY Last FISHER | | | | 4. DATE OF DEATH
Month OCT. Day 31 Year 19 57 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/16/50 | | 9. AGE (In years last birthday)
7 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
-none Schoolboy | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Bethesda, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
GEORGE WILLIAM FISHER, JR. | | | | 14. MOTHER'S MAIDEN NAME
GAY DAVIS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT
Police records
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia due to carbon monoxide poisoning (Accidental)
890.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(c) DUE TO
(c) cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chimney stopped up due to several dead birds and nest in chimney | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Found dead in home filled with gas and soot | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. ? p. m. ? 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Silver Spring, Montgoerny Co., Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i>
EXAMINER'S NAME (Type) FRANK J. BROSCART | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
10/31/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
11/4/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Nat'l. Mem. Park Cemetery | | 22d. LOCATION (City, town, or county) (State)
Falls Church, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Warner E. Humphrey</i>
ADDRESS
Silver Spring, Md. | | | | 24a. REC'D BY REGISTRAR
DATE NOV 4 1957 | | 24b. REGISTRAR'S SIGNATURE
<i>Charles Potter</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|--|
| 1. NAME OF DECEASED
JAMES EARL RAY | | 2. SEX
Male | | 3. AGE
35 | |
| 4. OCCUPATION
None | | 5. MARITAL STATUS
Single | | 6. PLACE OF BIRTH
Missouri | |
| 7. DATE OF DEATH
April 4, 1968 | | 8. TIME OF DEATH
10:00 AM | | 9. PLACE OF DEATH
Room 306, LBJ Library | |
| 10. CAUSE OF DEATH
Suicide by gunshot | | 11. MANNER OF DEATH
Homicide | | 12. SIGNATURE OF EXAMINER
[Signature] | |
| 13. SIGNATURE OF NEXT OF KIN
[Signature] | | 14. SIGNATURE OF WITNESS
[Signature] | | 15. SIGNATURE OF CORONER
[Signature] | |

BUREAU V. 3

NOV 4 1957

RECEIVED

10864

CERTIFICATE OF DEATH

10849

Reg. Dist. No. 216

| | | | | | | | |
|---|---|--|---|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE North Carolina b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | c. LENGTH OF STAY IN 1b
71 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Asheville 70 X-3 ✓ | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS
92 Arco Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First James Middle William Last Flynn | | | | 4. DATE OF DEATH
Month October Day 16, Year 1957 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 20, 1904 | | 9. AGE (In years last birthday)
53 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Clothing | | 11. BIRTHPLACE (State or foreign country)
New Jersey | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Patrick Flynn | | | | 14. MOTHER'S MAIDEN NAME
Kathryn O'Reilly | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC FAILURE
199.9
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MALIGNANT CARCINOMA
DUE TO
(c) BILATERAL LOWER LOBE PNEUMONIA | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
34RS- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
BILATERAL LOWER LOBE PNEUMONIA | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) | | | |
| 21. I certify that I attended the deceased from August 6, 1957 , to October 16, 1957 , that I last saw the deceased alive on October 16, 1957 , and that death occurred at 9:50 a.m. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Richard K Shaw | | M.D. The Clinical Center | | ADDRESS (Street, city or town, state)
National Institutes of Health | | DATE SIGNED
10/16/57 | |
| PHYSICIAN'S NAME (Type)
RICHARD K. SHAW, M. D. | | | | ADDRESS
Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Oct. 21, 1957 | 22c. NAME OF CEMETERY OR CREMATORY
Arlington Natl. Cem | | 22d. LOCATION (City, town, or county)
Arlington Va | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Nor. DeVol-2224 Wisconsin-DC | | | | 24a. REC'D BY REGISTRAR
DATE 10-21-57 | | 24b. REGISTRAR'S SIGNATURE
Beattie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 1, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10865

CERTIFICATE OF DEATH

10850
Reg. Dist. No. 223

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>8500 FLOWER AVE</u> | | c. LENGTH OF STAY IN 1b
<u>2 MOS.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>TAKOMA PARK</u> | | d. STREET ADDRESS
<u>18502 GREENWOOD AVE.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>LEILA</u> Middle <u>Y.</u> Last <u>FOWLER</u> | | 4. DATE OF DEATH
Month <u>OCT.</u> Day <u>31</u> Year <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>AUG. 27, 1880</u> |
| 9. AGE (In years lost birthday)
<u>77</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>AT HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>LOWER MARLBORO, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>RICHARD Z. YOUNGER</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARY GIBSON</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | |
| 17. INFORMANT
<u>MRS JOS. A. MALLOY, 8502 GREENWOOD AVE.</u> | | Address <u>TAKOMA PARK, MD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>arterio-sclerosis</u>
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH
<u>subacute</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. p. m. Month, Day, Year
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 20</u> , 19 <u>57</u> , to <u>Oct 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 28</u> , 19 <u>57</u> , and that death occurred at <u>9 a</u> . M, from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| ACTUAL SIGNATURE
<u>A. B. LITTLE MD</u> | | M.D. <u>6911 5th St NW, Wash, DC</u> | |
| PHYSICIAN'S NAME (Type)
<u>A. B. LITTLE MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>Nov 3, 1957</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>SMITHVILLE CHURCH CEM.</u> | 22d. LOCATION (City, town, or county) (State)
<u>SMITHVILLE, CALVERT CO., MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Arthur Walters</u> | | ADDRESS
<u>254 Carroll St. S.E.</u> | |
| 24a. REC'D BY REGISTRAR
<u>DATE 11/1/57</u> | | 24b. REGISTRAR'S SIGNATURE
<u>J. H. Noddt</u> | |

BUREAU V.

NOV 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10866

CERTIFICATE OF DEATH

Reg. Dist. No.

10851

| | | | | | | | |
|--|-------------------------------|--|------------------------------------|--|--|--|------------------|
| 1. PLACE OF DEATH
a. COUNTY County Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville | | | | c. LENGTH OF STAY IN 1b 30 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks ✓ | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilee Nursing Home | | | | d. STREET ADDRESS 10x2.2 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Hannah First Ann Middle Fry Last | | | | 4. DATE OF DEATH Oct Month 3 Day 19 Year 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 9 1871 | | 9. AGE (In years last birthday) 86 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Hough | | | | 14. MOTHER'S MAIDEN NAME Mary Timms | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT George N. Everhart, Bethesda, Md. Address 5037 Bradley | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myocardial disease
(c) Generalized arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic myocarditis
INTERVAL BETWEEN ONSET AND DEATH 2 weeks | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. ft. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 31, 1957 to Oct 3, 1957 that I last saw the deceased alive on Oct 3, 1957 , and that death occurred at 3:45 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 1301 Temporary Rd. Leesburg, Va. DATE SIGNED 10-4-57 | | | | | | | |
| ACTUAL SIGNATURE Dr. John Roger M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct 5 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Leesburg | | 22d. LOCATION (City, town, or county) (State) Leesburg Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wayne Barber ADDRESS Laytonsville, Md. | | | | 24a. REC'D BY REGISTRAR 11/2/57 DATE | | 24b. REGISTRAR'S SIGNATURE Frances Potter | |

10867

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase X2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Suburban Hospital | | | | d. STREET ADDRESS
8054 Glendale Road 1 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Rodger Middle D. Last GESSFORD | | | | 4. DATE OF DEATH
Month October Day 26 Year 19 57 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 17, 1899 | | 9. AGE (In years last birthday)
58 yrs. | IF UNDER 1 YEAR
Months 0 Days 9 | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Attorney | | 10b. KIND OF BUSINESS OR INDUSTRY
Patent Lawyer | | 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
James Gessford | | | | 14. MOTHER'S MAIDEN NAME
Margaret Dunn | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
W. W. I | | 17. INFORMANT
Ruth Gessford-Wife-Same Item #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Left Ventricular Failure
410X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Dis with Mitral Stenosis
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
16 hours
10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug. 19 , 19 57 , to Oct. 26 , 19 57 , that I last saw the deceased alive on October 26 , 19 57 , and that death occurred at 11:45 A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 6921 Clarendon Rd. Beth. Md. DATE SIGNED 10/26/1957 | | | | | | | |
| ACTUAL SIGNATURE Philip R. James M.D. | | | | 6921 Clarendon Road, Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) Philip R. James, M. D. | | | | 6921 Clarendon Road, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/29/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR
10-29-57 | | 24b. REGISTRAR'S SIGNATURE
Bernie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 31 1957

BUREAU V. 2

Robert A. Murphy-John W. Herndon

Washington National

Philip H. James, M.D.

0021

October 29

Oct 29 1957

RECEIVED

OCT 31 1957

Phonetic Board of the National

Acute Care Ventilator

Unknown

11

James Cassaro

Washington, D.C.

Male

October 29

68

October 29

October 29

October 29

Grady Chase

4004 Glenview Road

St. Ann Hospital

October 29

October 29

October 29

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10868

CERTIFICATE OF DEATH

10853

Reg. Dist. No.

216

| | | | | | | | |
|---|---|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
60 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Frederick Middle Lynn Last Goldeisen | | | | 4. DATE OF DEATH
Month October Day 5 Year 1957 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 14, 1903 | 9. AGE (In years last birthday)
53 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bus Driver | | 10b. KIND OF BUSINESS OR INDUSTRY
Transit Company | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Frederick Goldeisen | | | | 14. MOTHER'S MAIDEN NAME
Ida Reider | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-05-2919 | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA
163x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF RT. LUNG
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
30 min
11 months | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from August 6 , 19 57 , to October 5 , 19 57 , that I last saw the deceased alive on October 5 , 19 57 , and that death occurred at 7:30p M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Richard Shaw | | M.D. The Clinical Center | | ADDRESS (Street, city or town, state)
National Institutes of Health | | | |
| PHYSICIAN'S NAME (Type)
RICHARD SHAW, M. D. | | | | DATE SIGNED
10/6/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10-9-1957 | 22c. NAME OF CEMETERY OR CREMATORY
St. James | | 22d. LOCATION (City, town, or county) (State)
Carroll Co., Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
C. M. Waltz, | | | ADDRESS
Winfield, Maryland | | 24a. REC'D BY REGISTRAR
ACT 8 | | |
| | | | | | 24b. REGISTRAR'S SIGNATURE
Russie Thompson | | |

CERTIFICATE OF DEATH

See Back for Instructions

| | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED
[Illegible] | | 2. SEX
[Illegible] | | 3. AGE
[Illegible] | | 4. DATE OF BIRTH
[Illegible] | | 5. PLACE OF BIRTH
[Illegible] | | 6. OCCUPATION
[Illegible] | |
| 7. MARITAL STATUS
[Illegible] | | 8. COLOR
[Illegible] | | 9. RELIGION
[Illegible] | | 10. EDUCATION
[Illegible] | | 11. SOCIAL SECURITY NUMBER
[Illegible] | | 12. MOTHER'S MAIDEN NAME
[Illegible] | |
| 13. DATE OF DEATH
[Illegible] | | 14. TIME OF DEATH
[Illegible] | | 15. PLACE OF DEATH
[Illegible] | | 16. CAUSE OF DEATH
[Illegible] | | 17. MANNER OF DEATH
[Illegible] | | 18. SIGNATURE OF DECEASED
[Illegible] | |
| 19. SIGNATURE OF WITNESS
[Illegible] | | 20. SIGNATURE OF PHYSICIAN
[Illegible] | | 21. SIGNATURE OF MINISTER
[Illegible] | | 22. SIGNATURE OF CORONER
[Illegible] | | 23. SIGNATURE OF JUDGE
[Illegible] | | 24. SIGNATURE OF CLERK
[Illegible] | |

BUREAU V. S.

OCT 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 10854 | |
|--|--|-----------------------------------|---|---|---|-------------------------------------|---|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. 217 | |
| 1. PLACE OF DEATH
o. COUNTY Montgomery
MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montg. | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring RFD | | | c. LENGTH OF STAY IN 1b
2 mos. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
x2 Silver Spring | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | d. STREET ADDRESS
Rural | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Mary Ellen Grimes | | | | | 4. DATE OF DEATH
Month 10 Day 7 Year 1957 | | | | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/18/27 | | 9. AGE (In years last birthday)
29 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | |
| 13. FATHER'S NAME
John Walter Grimes | | | | | 14. MOTHER'S MAIDEN NAME
Estell King | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) #####
(If yes, give date of dates of service) ##### | | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
John W. Grimes Address Boyd's Md. | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diabetic Coma
260X DUE TO
Conditions, if any, which gave rise to immediate cause (b) _____
(a), stating the underlying cause last. DUE TO (c) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 10/9/57 | | | |
| 22a. BURIAL, CREMATION, REINTERMENT (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | | 22d. LOCATION (City, town, or county) (State) | | | | |
| Burial | | Oct, 10 | | 57 Bethesda Church | | | Browningsville Md. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Raymond Barber | | | | | ADDRESS
Laytonsville Md. | | | 24a. REC'D BY REGISTRAR
DATE 10-10-57 | | 24b. REGISTRAR'S SIGNATURE
Gertrude B. Lawler | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|----------------------------------|--|----------------------------------|--|----------------------------------|--|----------------------------------|--|----------------------------------|--|----------------------------------|--|
| NAME OF DECEASED
[Illegible] | | AGE
[Illegible] | | SEX
[Illegible] | | RACE
[Illegible] | | DATE OF DEATH
[Illegible] | | PLACE OF DEATH
[Illegible] | |
| MARRIAGE
[Illegible] | | EDUCATION
[Illegible] | | OCCUPATION
[Illegible] | | RELIGION
[Illegible] | | CAUSE OF DEATH
[Illegible] | | MANNER OF DEATH
[Illegible] | |
| SIGNED AND SEaled
[Illegible] | | SIGNED AND SEaled
[Illegible] | | SIGNED AND SEaled
[Illegible] | | SIGNED AND SEaled
[Illegible] | | SIGNED AND SEaled
[Illegible] | | SIGNED AND SEaled
[Illegible] | |

BUREAU V. S.

OCT 16 1957

RECEIVED

CERTIFICATE OF DEATH

10855
Reg. Dist. No. 215

10870

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Virginia</u>
b. COUNTY <u>Falls Church</u> <u>83X-3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda (Rural)</u> | | c. LENGTH OF STAY IN 1b
<u>2 months</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>U.S. Naval Hospital, Bethesda, Md.</u> | | e. STREET ADDRESS
<u>6701 N. 33rd Street</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Lillie</u> Middle <u>Young</u> Last <u>GULLETTE</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>23</u> Year <u>19 57</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>January 20, 1882</u> |
| 9. AGE (In years last birthday)
<u>75</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Housewife</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Alabama</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>George Young</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | |
| 17. INFORMANT
<u>(Son) George L. Gullette, (Same as #2)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Infarction, myocardium</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis + occlusion, Rt. coronary a.</u> 2 ⁺ mos
(c) <u>Arteriosclerosis</u> ? YEARS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Hour <u>19</u> Month <u>10</u> Day <u>23</u> Year <u>57</u>
a. m. p. m. | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>23 August</u> , 19 <u>57</u> , to <u>23 October</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>22 August</u> , 19 <u>57</u> , and that death occurred at <u>2:45 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W.B. Ingram</u> | | ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> | |
| DATE SIGNED <u>10-23-57</u> | | M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Wm. B. Ingram CDR MC USN</u> | | U.S. Naval Hospital, Bethesda, Md. 10-23-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Cremation</u> | <u>10-23-57</u> | <u>Cedar Hill Crematory</u> | <u>Prince George County, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>R.A. Pumphrey</u> | | ADDRESS
<u>7557 Wisconsin Ave. Bethesda Md.</u> | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE
<u>May E. Parrelly</u> | |
| DATE <u>10-23-57</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

512

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurring and low contrast.

BUREAU V. 1

OCT 25 1957

RECEIVED

10871

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|-------------------------------|--|--|---|--|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN TB <u>31 yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5923 Wilmett Road</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>GERTRUDE FRANCES HAMILL</u> | | | | 4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 11, 1892</u> | | 9. AGE (In years last birthday) <u>65</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Alston, Mass.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Alston, Mass.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Michael J. Reynolds</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine E. Dalton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT (Name and Address) <u>George K. Hamill 5923 Wilmett Rd. Bethesda, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastasis, generalized</u>
<u>170X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma, breast, right</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 weeks</u>
<u>15 months</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>October 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>October 14</u> , 19 <u>57</u> , and that death occurred at <u>2:40</u> P. M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave. Bethesda, Md</u> DATE SIGNED <u>10/14/57</u>
ACTUAL SIGNATURE <u>Robert N. Coale</u> M.D.
PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u> <u>4630 MONTGOMERY AVE. BETHESDA, MD</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/17/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey,</u> ADDRESS <u>Bethesda, Maryland</u> | | | | 24a. REC'D BY REGISTRAR <u>10-16-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10857

10872 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring 56 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2906 Stanton Ave. | | | | d. STREET ADDRESS
2906 Stanton Ave. | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Valerie Middle Kay Last Hammer | | | | 4. DATE OF DEATH
Month Oct. Day 10 Year 1957 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 18, 1952 | |
| 9. AGE (In years last birthday)
5 yrs. | | IF UNDER 1 YEAR
Months 5 Days 10 | | IF UNDER 24 HRS.
Hours 10 Min. 57 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Ft. Campbell, Kentucky | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
James S. Hammer | | | | 14. MOTHER'S MAIDEN NAME
Dolores J. Andrus | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Mr. James S. Hammer | | Address
Item #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain Stem Glioma Tumor
193x DUE TO
Conditions, if any, which gave rise to immediate cause (b) _____
(a), stating the underlying cause last. DUE TO (c) _____
INTERVAL BETWEEN ONSET AND DEATH
1 1/2 yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10/14/57 | | 22c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NAT'L. CEMETERY | | 22d. LOCATION (City, town, or county) _____ (State) _____
ARLINGTON, VIRGINIA | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Warner B. Humphrey | | | | ADDRESS
SILVER SPRING, MARYLAND | | 24a. REC'D BY REGISTRAR
DATE OCT 14 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Frances P. Patter | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10858

10873

CERTIFICATE OF DEATH

Reg. Dist. No.

217

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Olney</u> | | c. LENGTH OF STAY IN 1b
<u>7 hours</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Montgomery County General Hospital, Inc.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Baby</u> Middle <u>Girl</u> Last <u>Hammond</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>2</u> Year <u>19 57</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>October 2, 1957</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NONE</u> | | 9. AGE (In years last birthday) yrs. <u>6</u> Min. <u>30</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY
<u>NONE</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>Spencer A. Hammond</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 14. MOTHER'S MAIDEN NAME
<u>Dorothy Jane Young</u> | |
| 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>Dorothy J. Hammond</u> Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Prematurity (1 lb. 5 1/2 oz.)</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cause unknown, 7 hours.</u>
DUE TO
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>o. n.</u> <u>19</u>
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>October 2</u> , 19 <u>57</u> , to <u>October 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>October 2</u> , 19 <u>57</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Clarksville, Maryland</u> DATE SIGNED _____
ACTUAL SIGNATURE <u>C. Whitaker</u>
PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M. D.</u> <u>Clarksville, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>10-3-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>BUSHY PARK</u> | | 22d. LOCATION (City, town, or county) (State)
<u>COOKSVILLE, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>F. C. HIGGINS, BATHORY, ELLICOTT CITY MD</u> | | 24a. REC'D BY REGISTRAR
<u>10 OCT 4 1957</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE
<u>Gertrude Lawley</u> | |

CERTIFICATE OF DEATH

11075

See, Sec. 10

| | | | | | | | | | | | | | | | |
|------------------|--|----------------|--|-----------------|--|-----------------|--|------------------|--|-------------------|--|--------------------|--|-------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. HARRIS | | Male | | 35 | | 1880 | | BALTIMORE | | BALTIMORE | | MARYLAND | | UNITED STATES | |
| RACE | | COLOR | | RELIGION | | MARRIAGE | | EDUCATION | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | |
| White | | White | | Roman Catholic | | Married | | High School | | Carpenter | | Heart Disease | | Natural | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | DATE OF INTERMENT | | PLACE OF INTERMENT | | CITY OF INTERMENT | |
| October 1, 1957 | | BALTIMORE | | BALTIMORE | | MARYLAND | | UNITED STATES | | October 1, 1957 | | BALTIMORE | | BALTIMORE | |
| TIME OF DEATH | | HOURS | | MINUTES | | AM | | PM | | DATE OF REPORT | | PLACE OF REPORT | | CITY OF REPORT | |
| 10:00 | | 10 | | 00 | | AM | | PM | | October 2, 1957 | | BALTIMORE | | BALTIMORE | |
| REPORTED BY | | RELATIONSHIP | | DATE OF REPORT | | PLACE OF REPORT | | CITY OF REPORT | | STATE OF REPORT | | COUNTRY OF REPORT | | MANNER OF DEATH | |
| JAMES H. HARRIS | | Wife | | October 2, 1957 | | BALTIMORE | | BALTIMORE | | MARYLAND | | UNITED STATES | | Natural | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | DATE OF INTERMENT | | PLACE OF INTERMENT | | CITY OF INTERMENT | |
| October 1, 1957 | | BALTIMORE | | BALTIMORE | | MARYLAND | | UNITED STATES | | October 1, 1957 | | BALTIMORE | | BALTIMORE | |
| TIME OF DEATH | | HOURS | | MINUTES | | AM | | PM | | DATE OF REPORT | | PLACE OF REPORT | | CITY OF REPORT | |
| 10:00 | | 10 | | 00 | | AM | | PM | | October 2, 1957 | | BALTIMORE | | BALTIMORE | |
| REPORTED BY | | RELATIONSHIP | | DATE OF REPORT | | PLACE OF REPORT | | CITY OF REPORT | | STATE OF REPORT | | COUNTRY OF REPORT | | MANNER OF DEATH | |
| JAMES H. HARRIS | | Wife | | October 2, 1957 | | BALTIMORE | | BALTIMORE | | MARYLAND | | UNITED STATES | | Natural | |

BUREAU V. 3

OCT 4 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. LENGTH OF STAY IN 1b <u>2 1/2 mo.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>WILLIAM ALLOYWISIS HANS</u> | | 4. DATE OF DEATH Month Day Year
<u>OCT 17 19 57</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN 21-1893</u> |
| 9a. AGE (In years last birthday) <u>64</u> yrs. | | 9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>ACCOUNTANT</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>Unk</u> | | 14. MOTHER'S MAIDEN NAME <u>Unk</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR I</u> | | 16. SOCIAL SECURITY NO. <u>Unk</u> | |
| 17. INFORMANT <u>MRS CATHERINE E ATWOOD</u> Address <u>110 INDIAN SPRING DR.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
<u>331x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Essential Hypertension</u> DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
<u>10 years</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Dec 15, 1956</u> to <u>OCT 17 1957</u> that I last saw the deceased alive on <u>OCT 17 1957</u> , and that death occurred at <u>1:30 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John J. Curry</u> M.D. <u>10620 Georgia Ave</u> | | ADDRESS (Street, city or town, state) <u>Indian Spring, Md</u> DATE SIGNED <u>10/17/57</u> | |
| PHYSICIAN'S NAME (Type) <u>John J. Curry</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10/22/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u> | 22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W K Huntemann & Son</u> ADDRESS <u>5732 Georgia Ave N.W</u> | | 24a. REC'D BY REGISTRAR <u>DATE 10-21-57</u> | 24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

10875

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | | c. LENGTH OF STAY IN 1b
5 YRS. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
10,300 BROOKMOOR DRIVE | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First DELLA Middle R. Last HARRINGTON | | | | 4. DATE OF DEATH
Month OCT. Day 11 Year 1957 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1/18/99 | |
| 9. AGE (In years last birthday)
58 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Bank | | 11. BIRTHPLACE (State or foreign country)
Boston, Mass. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Augustus E. Rose | | | | 14. MOTHER'S MAIDEN NAME
Della O'Malley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
577-20-9221 | | 17. INFORMANT
Mr. John A. Harrington, 10,300 Brookmoor Drive | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, metastatic
199.9 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. | | Month, Day, Year
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 18, 1957 , to Oct. 11, 1957 , that I last saw the deceased alive on Oct. 10, 1957 , and that death occurred at 4:40 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE A. F. Thibadeau | | | | ADDRESS (Street, city or town, state) 10111 Colosville Rd. Silver Spring, Md. | | | |
| PHYSICIAN'S NAME (Type) A. F. THIBADEAU | | | | DATE SIGNED 10/14/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
TRANS. & BURIAL | | 22b. DATE THEREOF
10/14/57 | | 22c. NAME OF CEMETERY OR CREMATORY
HOLY CROSS CEMETERY | | 22d. LOCATION (City, town, or county) (State)
MALDEN, MASS. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Warner E. Humphrey | | | | ADDRESS
SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR
14-1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Frances P. [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED
[REDACTED] | | 2. SEX
[REDACTED] | | 3. AGE
[REDACTED] | | 4. DATE OF BIRTH
[REDACTED] | |
| 5. PLACE OF BIRTH
[REDACTED] | | 6. OCCUPATION
[REDACTED] | | 7. MARITAL STATUS
[REDACTED] | | 8. COLOR
[REDACTED] | |
| 9. CAUSE OF DEATH
[REDACTED] | | 10. MANNER OF DEATH
[REDACTED] | | 11. PLACE OF DEATH
[REDACTED] | | 12. DATE OF DEATH
[REDACTED] | |
| 13. SIGNATURE OF PHYSICIAN
[REDACTED] | | 14. SIGNATURE OF CORONER
[REDACTED] | | 15. SIGNATURE OF DECEASED
[REDACTED] | | 16. SIGNATURE OF WITNESS
[REDACTED] | |
| 17. SIGNATURE OF REGISTRAR
[REDACTED] | | 18. SIGNATURE OF CLERK
[REDACTED] | | 19. SIGNATURE OF [REDACTED] | | 20. SIGNATURE OF [REDACTED] | |
| 21. SIGNATURE OF [REDACTED] | | 22. SIGNATURE OF [REDACTED] | | 23. SIGNATURE OF [REDACTED] | | 24. SIGNATURE OF [REDACTED] | |
| 25. SIGNATURE OF [REDACTED] | | 26. SIGNATURE OF [REDACTED] | | 27. SIGNATURE OF [REDACTED] | | 28. SIGNATURE OF [REDACTED] | |
| 29. SIGNATURE OF [REDACTED] | | 30. SIGNATURE OF [REDACTED] | | 31. SIGNATURE OF [REDACTED] | | 32. SIGNATURE OF [REDACTED] | |
| 33. SIGNATURE OF [REDACTED] | | 34. SIGNATURE OF [REDACTED] | | 35. SIGNATURE OF [REDACTED] | | 36. SIGNATURE OF [REDACTED] | |
| 37. SIGNATURE OF [REDACTED] | | 38. SIGNATURE OF [REDACTED] | | 39. SIGNATURE OF [REDACTED] | | 40. SIGNATURE OF [REDACTED] | |
| 41. SIGNATURE OF [REDACTED] | | 42. SIGNATURE OF [REDACTED] | | 43. SIGNATURE OF [REDACTED] | | 44. SIGNATURE OF [REDACTED] | |
| 45. SIGNATURE OF [REDACTED] | | 46. SIGNATURE OF [REDACTED] | | 47. SIGNATURE OF [REDACTED] | | 48. SIGNATURE OF [REDACTED] | |
| 49. SIGNATURE OF [REDACTED] | | 50. SIGNATURE OF [REDACTED] | | 51. SIGNATURE OF [REDACTED] | | 52. SIGNATURE OF [REDACTED] | |
| 53. SIGNATURE OF [REDACTED] | | 54. SIGNATURE OF [REDACTED] | | 55. SIGNATURE OF [REDACTED] | | 56. SIGNATURE OF [REDACTED] | |
| 57. SIGNATURE OF [REDACTED] | | 58. SIGNATURE OF [REDACTED] | | 59. SIGNATURE OF [REDACTED] | | 60. SIGNATURE OF [REDACTED] | |
| 61. SIGNATURE OF [REDACTED] | | 62. SIGNATURE OF [REDACTED] | | 63. SIGNATURE OF [REDACTED] | | 64. SIGNATURE OF [REDACTED] | |
| 65. SIGNATURE OF [REDACTED] | | 66. SIGNATURE OF [REDACTED] | | 67. SIGNATURE OF [REDACTED] | | 68. SIGNATURE OF [REDACTED] | |
| 69. SIGNATURE OF [REDACTED] | | 70. SIGNATURE OF [REDACTED] | | 71. SIGNATURE OF [REDACTED] | | 72. SIGNATURE OF [REDACTED] | |
| 73. SIGNATURE OF [REDACTED] | | 74. SIGNATURE OF [REDACTED] | | 75. SIGNATURE OF [REDACTED] | | 76. SIGNATURE OF [REDACTED] | |
| 77. SIGNATURE OF [REDACTED] | | 78. SIGNATURE OF [REDACTED] | | 79. SIGNATURE OF [REDACTED] | | 80. SIGNATURE OF [REDACTED] | |
| 81. SIGNATURE OF [REDACTED] | | 82. SIGNATURE OF [REDACTED] | | 83. SIGNATURE OF [REDACTED] | | 84. SIGNATURE OF [REDACTED] | |
| 85. SIGNATURE OF [REDACTED] | | 86. SIGNATURE OF [REDACTED] | | 87. SIGNATURE OF [REDACTED] | | 88. SIGNATURE OF [REDACTED] | |
| 89. SIGNATURE OF [REDACTED] | | 90. SIGNATURE OF [REDACTED] | | 91. SIGNATURE OF [REDACTED] | | 92. SIGNATURE OF [REDACTED] | |
| 93. SIGNATURE OF [REDACTED] | | 94. SIGNATURE OF [REDACTED] | | 95. SIGNATURE OF [REDACTED] | | 96. SIGNATURE OF [REDACTED] | |
| 97. SIGNATURE OF [REDACTED] | | 98. SIGNATURE OF [REDACTED] | | 99. SIGNATURE OF [REDACTED] | | 100. SIGNATURE OF [REDACTED] | |

BUREAU V. 1

OCT 14 1957

RECEIVED

10794

CERTIFICATE OF DEATH

Reg. Dist. No.

773

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
o. STATE D. C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | |
| c. LENGTH OF STAY IN 1b 16 days | | | | d. STREET ADDRESS 4740 Conn. Ave. N.W. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Elisa Elizabeth Hart | | | | 4. DATE OF DEATH Month Day Year
OCT 16 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 10, 1881 | |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) D.C. | | 12. CITIZEN OF WHAT COUNTRY? Amer | |
| 13. FATHER'S NAME John A. Swedberg | | | | 14. MOTHER'S MAIDEN NAME Hedwig E. Lundberg | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Rupture of Myocardium
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion
(c) Arteriosclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH Terminal
Three days?
? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 1955 , 19 Oct 16 , 19 57 , that I last saw the deceased alive on Oct 15 , 19 57 , and that death occurred at 4:45 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Robert A. Hare | | | | ADDRESS (Street, city or town, state) Takoma Park, Md. | | | |
| DATE SIGNED 10/16/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) Robert A. Hare M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) cremation | | 22b. DATE THEREOF 10/18/57 | | 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | | 22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. | | | | ADDRESS Wash, D.C. | | 24a. REC'D BY REGISTRAR OCT 17 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE J. Wilson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 10

Form No. 10

THE DECEASED

NAME OF DECEASED

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Nurse

Signature of Chaplain

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

BUREAU V. 3

OCT 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10795

CERTIFICATE OF DEATH

Reg. Dist. No.

10862 473

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bethesda</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u> | | d. STREET ADDRESS <u>14545 S. Chelsea Lane</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Winfred</u> Last <u>Headden</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1957</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 22, 1890</u> |
| 9. AGE (In years last birthday) <u>67</u> yrs. | | IF UNDER 1 YEAR: Months <u>6</u> Days <u>7</u> Hours <u>15</u> Min. <u>00</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Purolator Products</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New Jersey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> | |
| 13. FATHER'S NAME <u>Jonathan Headden</u> | | 14. MOTHER'S MAIDEN NAME <u>Nelly (UNKNOWN)</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Washington San. & Hosp. Records</u> | |
| 17. INFORMANT <u>Washington San. & Hosp. Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chr. Passive Congestion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Edema</u>
DUE TO (c) <u>Coronary Infarction - Massive</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
<u>5 1/2 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10-4-</u> , 19 <u>57</u> , to <u>10/9/</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/9/</u> , 19 <u>57</u> , and that death occurred at <u>1:55 P.</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D. | | ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>10/9/57</u> | |
| PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur.-Transit</u> | | 22b. DATE THEREOF <u>10/12/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u> | | 22d. LOCATION (City, town, or county) (State) <u>Red Bank, New Jersey</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>A. C. Bumphey</u> ADDRESS <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>OCT 14 1957</u> 24b. REGISTRAR'S SIGNATURE <u>William J. Addy</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------|--|-------------------------|--|--------------------------|--|-------------------|--|---------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1922 | | MOBILE, ALABAMA | |
| MARRIAGE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | NAME OF SPOUSE | | DATE OF DEATH | | PLACE OF DEATH | |
| MARRIED | | 1945 | | MEMPHIS, TENNESSEE | | JANE E. RAY | | 4/4/68 | | MEMPHIS, TENNESSEE | |
| OCCUPATION | | DATE OF OCCUPATION | | PLACE OF OCCUPATION | | NAME OF EMPLOYER | | DATE OF DEATH | | PLACE OF DEATH | |
| CONTRACTOR | | 1955 | | MEMPHIS, TENNESSEE | | RAY, JAMES EARL | | 4/4/68 | | MEMPHIS, TENNESSEE | |
| CAUSE OF DEATH | | DATE OF CAUSE OF DEATH | | PLACE OF CAUSE OF DEATH | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| HEART DISEASE | | 1968 | | MEMPHIS, TENNESSEE | | DR. J. H. HARRIS | | 4/4/68 | | MEMPHIS, TENNESSEE | |
| MANNER OF DEATH | | DATE OF MANNER OF DEATH | | PLACE OF MANNER OF DEATH | | NAME OF CORoner | | DATE OF DEATH | | PLACE OF DEATH | |
| NATURAL | | 1968 | | MEMPHIS, TENNESSEE | | DR. J. H. HARRIS | | 4/4/68 | | MEMPHIS, TENNESSEE | |
| SIGNATURE OF PHYSICIAN | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| J. H. HARRIS | | 4/4/68 | | MEMPHIS, TENNESSEE | | DR. J. H. HARRIS | | 4/4/68 | | MEMPHIS, TENNESSEE | |
| SIGNATURE OF CORoner | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | | NAME OF CORoner | | DATE OF DEATH | | PLACE OF DEATH | |
| J. H. HARRIS | | 4/4/68 | | MEMPHIS, TENNESSEE | | DR. J. H. HARRIS | | 4/4/68 | | MEMPHIS, TENNESSEE | |

BUREAU V. S.

OCT 14 1957

RECEIVED

10876

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | | c. LENGTH OF STAY IN 1b
4 months | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
56 SILVER SPRING | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
510 WARRENTON DRIVE | | | | d. STREET ADDRESS
1 510 WARRENTON DRIVE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First LORETTA Middle ANN Last HEIBERGER | | | | 4. DATE OF DEATH
Month OCT. Day 22 Year 1957 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
NOV. 16, 1882 | |
| 9. AGE (In years last birthday)
74 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOMEMAKER | | | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
PATRICK KIERNAN | | | | 14. MOTHER'S MAIDEN NAME
CATHERINE KIERNAN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
Address
Mrs. Rita M. Gilliam, 510 Warrenton Drive Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension
DUE TO (c) Atherosclerosis
INTERVAL BETWEEN ONSET AND DEATH
1 day
10-15 yrs
? | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 1952 to 10/22 , 1957 that I last saw the deceased alive on 10/22 , 1957 , and that death occurred at 9:30 P. M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 906 Lakeside Rd Silver Spring, Md. DATE SIGNED 10/23/57 | | | | | | | |
| ACTUAL SIGNATURE William D. Aud M.D. | | | | PHYSICIAN'S NAME (Type) WILLIAM D. AUD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10/25/57 | | 22c. NAME OF CEMETERY OR CREMATORY
MT. OLIVET CEMETERY | | 22d. LOCATION (City, town, or county) (State)
WASHINGTON, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. E. Humphrey ADDRESS
SILVER SPRING, MD. | | | | 24a. REC'D BY REGISTRAR
DATE 25 1957 | | 24b. REGISTRAR'S SIGNATURE
Frances Patter | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

OCT 23 1957

RECEIVED

10877

CERTIFICATE OF DEATH

Reg. Dist. No.

10864
223

| | | | | | | | |
|--|-------------------------------|--|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>Washington Sanitarium and Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Brenda</u> Middle <u>Lee</u> Last <u>Hill</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1957</u> | | | |
| 5. SEX <u>Girl</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>October 2, 1957</u> | 9. AGE (In years last birthday) yrs. <u>2</u> | IF UNDER 1 YEAR Months <u>2</u> Days <u>11</u> Hours <u>33</u> | IF UNDER 24 HRS. Min. <u>33</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Eugene V. Owens</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Hill, Margaret Frances (Miss)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>Mother</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>HYALIN MEMBRANE DISEASE</u>
<u>527.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. <u>19</u> | Month <u>10</u> | Day <u>5</u> | Year <u>1957</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>2 OCTOBER 1957</u> to <u>5 OCTOBER 1957</u> that I last saw the deceased alive on <u>4 OCTOBER 1957</u> , and that death occurred at <u>1011 Georgia Ave Silver Spring Md</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED <u>10-5-57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Henry Stout</u> | | M.D. <u>1011 Georgia Ave Silver Spring Md</u> | | | | | |
| PHYSICIAN'S NAME (Type) <u>Henry Stout, M. D.</u> | | Silver Spring, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>10-6-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, Md.</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Lane M.D.</u> ADDRESS <u>Wash. San. & Hosp.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>10/8/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>William Dodd</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075291XV5

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

OCT 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10865

10878

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | |
|---|--|--|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 KENSINGTON</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3402 NIMITZ ROAD Apt. C6</u> | | | d. STREET ADDRESS <u>3402 NIMITZ ROAD, APT. C6</u> | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>George WILLIAM HILL</u> | | | 4. DATE OF DEATH <u>Oct 29 1957</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/3/09</u> | 9. AGE (In years last birthday) <u>48</u> yrs. | IF UNDER 1 YEAR: Months <u>29</u> Days <u>29</u> Hours <u>19</u> Min. <u>57</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master Sgt. (retired)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u> | | 11. BIRTHPLACE (State or foreign country) <u>Danville, Virginia</u> | |
| 13. FATHER'S NAME <u>William Henry Hill</u> | | 14. MOTHER'S MAIDEN NAME <u>Pamella Jane Walton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give way or dates of service) <u>WW #2</u> | | 16. SOCIAL SECURITY NO. <u>245-07-6001</u> | | 17. INFORMANT <u>Mrs. Anna S. Hill, 3402 Nimitz Rd., Apt. C6 Kensington, Maryland</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1 CORONARY OCCLUSION</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____
DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u>19</u>
p. m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Oct 29, 1957</u> to <u>Oct 29, 1957</u> , that I last saw the deceased alive on <u>Oct 29, 1957</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>10609 CANNON ST KENSINGTON, MD</u> DATE SIGNED <u>Oct 29-57</u> | | | | | |
| ACTUAL SIGNATURE <u>Robert T. Thibadeau</u> M.D. | | | | | |
| PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u> <u>KENSINGTON, MD</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>11/1/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u> | | 22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u> (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD</u> | | | 24a. REC'D BY REGISTRAR <u>NOV 1 1957</u> | 24b. REGISTRAR'S SIGNATURE <u>Francis Potter</u> | |

23

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------|--|-----------------|--|-------------------------|--|------------------|--|---------------|--|----------------|--|---------------|--|------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. HARRIS | | 45 | | M | | W | | 1880 | | BALTIMORE | | MD | | U.S.A. | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | COUNTRY OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | COUNTRY OF DEATH | |
| JAN 10 1902 | | BALTIMORE | | MD | | U.S.A. | | JAN 10 1902 | | BALTIMORE | | MD | | U.S.A. | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | | POST-MORTEM | | FINDINGS | | REMARKS | |
| HEART DISEASE | | NATURAL | | CORONARY ARTERY DISEASE | | ANGINA PECTORIS | | DIGITALIS | | NO | | NO | | NO | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | COUNTRY OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | COUNTRY OF DEATH | |
| JAN 10 1902 | | BALTIMORE | | MD | | U.S.A. | | JAN 10 1902 | | BALTIMORE | | MD | | U.S.A. | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | | POST-MORTEM | | FINDINGS | | REMARKS | |
| HEART DISEASE | | NATURAL | | CORONARY ARTERY DISEASE | | ANGINA PECTORIS | | DIGITALIS | | NO | | NO | | NO | |

BUREAU V. S.

NOV 1 1902

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 108156

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b
11 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Md. | | | | e. STREET ADDRESS
3803 Everett Street | | | |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Tom Middle Burbridge Last HILL | | | | 4. DATE OF DEATH
Month October Day 21 Year 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12 December 1898 | |
| 9. AGE (In years last birthday)
58 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mariner | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy (Retired) | | 11. BIRTHPLACE (State or foreign country)
Texas | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | | | | | |
| 13. FATHER'S NAME
Benjamin HILL | | | | 14. MOTHER'S MAIDEN NAME
Norma BURBRIDGE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes 33 years | | | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
(Wife) Mrs. Lillian J. HILL (Same As #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, Broncho
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis, Multiple
DUE TO
(c) Hypertensive Cardio Vascular Disease | | | | INTERVAL BETWEEN ONSET AND DEATH
6 days
3 years
9 Years + | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 10 Oct. , 19 57 , to 21 Oct. , 19 57 , that I last saw the deceased alive on 21 Oct. , 19 57 , and that death occurred at 7:10 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Thirl Jarrett M.D. U.S. Naval Hospital, Bethesda, Md. 10-21-57 | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | |
| PHYSICIAN'S NAME (Type) Thirl Jarrett, CAPT. MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-20-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington Natl Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R.A. Humphrey | | | | ADDRESS
1557 Wisconsin Ave. Bethesda, Md. | | 24a. REC'D BY REGISTRAR
DATE 10-21-57 | |
| 24b. REGISTRAR'S SIGNATURE
Mary E. Parrelly | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | | | | | | | |
|------------------|--|------|--|-----------|--|-------------------|--|----------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | Male | | 35 | | 1922 | | Baltimore, Md. | |
| MARRIAGE | | DATE | | PLACE | | NAME OF SPOUSE | | DATE OF DEATH | |
| Married | | 1945 | | Baltimore | | Mary H. Harris | | 1957 | |
| OCCUPATION | | DATE | | PLACE | | NAME OF EMPLOYER | | DATE OF DEATH | |
| Teacher | | 1950 | | Baltimore | | St. Mary's School | | 1957 | |
| CAUSE OF DEATH | | DATE | | PLACE | | NAME OF PHYSICIAN | | DATE OF DEATH | |
| Heart Disease | | 1957 | | Baltimore | | Dr. J. H. Harris | | 1957 | |
| MANNER OF DEATH | | DATE | | PLACE | | NAME OF CORONER | | DATE OF DEATH | |
| Natural | | 1957 | | Baltimore | | John H. Harris | | 1957 | |
| EDUCATION | | DATE | | PLACE | | NAME OF SCHOOL | | DATE OF DEATH | |
| High School | | 1940 | | Baltimore | | St. Mary's School | | 1957 | |
| RELIGION | | DATE | | PLACE | | NAME OF CHURCH | | DATE OF DEATH | |
| Catholic | | 1940 | | Baltimore | | St. Mary's Church | | 1957 | |
| MILITARY SERVICE | | DATE | | PLACE | | NAME OF SERVICE | | DATE OF DEATH | |
| None | | 1957 | | Baltimore | | None | | 1957 | |
| FAMILY HISTORY | | DATE | | PLACE | | NAME OF FAMILY | | DATE OF DEATH | |
| None | | 1957 | | Baltimore | | None | | 1957 | |
| PREVIOUS ILLNESS | | DATE | | PLACE | | NAME OF ILLNESS | | DATE OF DEATH | |
| None | | 1957 | | Baltimore | | None | | 1957 | |
| TREATMENT | | DATE | | PLACE | | NAME OF TREATMENT | | DATE OF DEATH | |
| None | | 1957 | | Baltimore | | None | | 1957 | |
| BURIAL | | DATE | | PLACE | | NAME OF BURIAL | | DATE OF DEATH | |
| None | | 1957 | | Baltimore | | None | | 1957 | |

BUREAU V. S.

OCT. 28. 1957

RECEIVED

10880

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | |
|---|---|---|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery Co. MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Springs | | c. LENGTH OF STAY IN 1b
5 Years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
56 Silver Springs, Maryland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | d. STREET ADDRESS
12308- Kimball Place | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
MARY First E. Middle HOFFMAN Last | | | 4. DATE OF DEATH Oct. Month 23rd. Day 19 Year 57 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 22- 1872 | 9. AGE (In years last birthday)
85 yrs. | IF UNDER 1 YEAR: Months Days Hours Min.
IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Domestic | | 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | |
| 13. FATHER'S NAME
Thomas M. Berkeley | | | 14. MOTHER'S MAIDEN NAME
Amanda B. Allen | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs Ethel M. Redding Address SAME AS # 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 442x Cerebral arteriosclerosis
DUE TO Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 20 years | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from July 21, 1937 to Oct 23, 1957 that I last saw the deceased alive on Oct 23, 1957 and that death occurred at 12 PM M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 35 New York Ave., N.W. Washington DATE SIGNED 10/23/57
ACTUAL SIGNATURE Chester J. Brady M.D. DO.
PHYSICIAN'S NAME (Type) CHESTER J. BRADY | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
Oct. 26- 1957 | 22c. NAME OF CEMETERY OR CREMATORY
Congressional Cemetery | 22d. LOCATION (City, town, or county) (State)
Washington, D.C. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Summers Brothers | | 1661- ADDRESS
Good Hope Road S.E. Washington, D.C. | | 24a. REC'D BY REGISTRAR
CT 25 1957 | 24b. REGISTRAR'S SIGNATURE
Francis Potter |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 10

OCT 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10868 2/6
Reg. Dist. No.

10881

| | | | |
|---|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring X2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nesmore Sanitarium Hospital</u> | | d. STREET ADDRESS <u>P.O. Box 94</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Alice</u> First Middle Last <u>Hopkins</u> | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>22 Aug 1878</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>France</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Samuel English Hopkins</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Thompson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>1</u> | |
| 17. INFORMANT <u>Hospital records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Terminal broncho-pneumonia</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cardio-vascular renal disease</u>
DUE TO
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 da.</u>
<u>6 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. <u>9</u> p. m. 19 <u>57</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 31</u> , 19 <u>57</u> , to <u>31 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>57</u> , and that death occurred at <u>1232</u> PM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>1822 Biltmore St. NW.</u> DATE SIGNED <u>10-31-57</u> | | | |
| ACTUAL SIGNATURE <u>E. E. Quayle</u> M.D. | | ADDRESS (Street, city or town, state) <u>Washington D.C.</u> | |
| PHYSICIAN'S NAME (Type) <u>E. E. Quayle M.D.</u> | | ADDRESS <u>Washington D.C.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov 2 1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Thompson</u> | | ADDRESS <u>1822 Biltmore St. NW.</u> | |
| 24a. REC'D BY REGISTRAR <u>NOV 5 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Fessie Thompson</u> | |

RECEIVED
NOV 5 1957
BUREAU V. S.

10796

CERTIFICATE OF DEATH

Reg. Dist. No.

10862/3

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b
<u>1 day</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Washington Sanatorium + Hosp.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>ANTON</u> Middle <u>(None)</u> Last <u>HORAK</u> | | | | 4. DATE OF DEATH
Month <u>OCT</u> Day <u>9</u> Year <u>1957</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Oct. 4, 1894</u> | |
| 9. AGE (In years lost birthday) yrs. <u>63</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Farm</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Yugoslavia</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>AMEB.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Vincent Horak</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>yes</u> <u>WWI</u> | | | | 16. SOCIAL SECURITY NO.
<u>No</u> | | 17. INFORMANT
<u>Hospital Records</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 day</u>
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>1954</u> to <u>9 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9 Oct</u> , 19 <u>57</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state)
<u>9086 Colosville Rd Silver Spring Md</u> | | | | DATE SIGNED
<u>10/10/57</u> | | | |
| ACTUAL SIGNATURE
<u>William D. Aud</u> | | | | M.D. <u>William D. Aud</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>William D. Aud, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10/12/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. John's Catholic Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Forest Glen Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner E. Humphrey</u> | | | | ADDRESS
<u>8434 La Monte Rd</u> | | 24a. REC'D BY REGISTRAR
<u>55</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>John L. Saddy</u> | | | | DATE
<u>OCT 14 1957</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 14 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10870

10882

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Dist. Of Col. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring, | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington, D.C. 47x-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Marilea Nursing Home
14511-Colesville Road | | | | d. STREET ADDRESS
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First SEBA Middle LEOTA Last HOSICK | | 4. DATE OF DEATH
Month Oct. Day 20 Year 1957 | | 5. SEX
Female | | 6. COLOR OR RACE
White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
October 22, 1872 | | 9. AGE (In years last birthday)
84 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months 11 Days 28 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Yankton, Dakota Territory | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Hosick | | | | 14. MOTHER'S MAIDEN NAME
Asenath Hosick | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Mrs. Gail Auerbach Address Westmoreland Hills, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocardial infarction DUE TO
(c) Thrombosed atherosclerosis DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1/2 hr.
3 years
3 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. 11. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 6, 1957 to Oct. 20, 1957 , that I last saw the deceased alive on Oct. 14, 1957 and that death occurred at 4:45 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 1919 Seminary Rd. Silver Spring, Md. DATE SIGNED 10-20-57 | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. | | | | PHYSICIAN'S NAME (Type) John S. Rogers, M.D., 1919-Seminary Road, Silver Spring, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
OCT. 22, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Suitland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Martin W. Hysong Co. | | | | ADDRESS
1300 N St. N.W., Wash. D.C. | | 24a. REC'D BY REGISTRAR
22 1957 24b. REGISTRAR'S SIGNATURE
Frances Pitter | |

10883

CERTIFICATE OF DEATH

10871
Reg. Dist. No.

218

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gaithersburg | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
x2 Rural — Colesville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Ammons Nursing Home | | | | d. STREET ADDRESS
1 Silver Springs, Md. Route # 2 | | | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle U. Last HOWARD | | | | 4. DATE OF DEATH
Month Oct. Day 2 Year 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Apr. 15, 1869 | |
| 9. AGE (In years last birthday) yrs. 88 | | IF UNDER 1 YEAR
Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs Florence Boston | | Address
Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Embolism
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis Coronary & General
DUE TO
(c) Cardiorenal Hypertension | | INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arthritis | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour o. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 20 , 19 53 , to Oct. 2 , 19 57 , that I last saw the deceased alive on Oct. 1 , 19 57 , and that death occurred at 8 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Norbeck Rt. 1 Silver Spring, Md. DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Webster Sewell, M.D. | | | | M.D. Norbeck Rt. 1 Silver Spring, Md. | | | |
| PHYSICIAN'S NAME (Type) Webster Sewell, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/5/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Good Hope | | 22d. LOCATION (City, town, or county) (State)
Colesville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert L. Shorden | | | | ADDRESS
Rockville, Md. | | 24a. REC'D BY REGISTRAR
DATE Oct 8 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Alfred G. Cook | | | |

CERTIFICATE OF DEATH

| | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|-----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | |
| JAMES H. COLEMAN | | Male | | 38 | | April 16, 1928 | |
| PLACE OF BIRTH | | RACE | | OCCUPATION | | EDUCATION | |
| Baltimore, Md. | | Colored | | Unemployed | | None | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | |
| April 16, 1957 | | Baltimore, Md. | | Heart Disease | | Natural | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| April 16, 1957 | | April 16, 1957 | | April 16, 1957 | | April 16, 1957 | |

BUREAU V. 2

OCT 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10872

10884

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS
5155 Macomb Street, N.W. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Lena Middle Ivan Last HUDSON | | | | 4. DATE OF DEATH
Month October Day 25 Year 1957 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1 July 1873 | |
| 9. AGE (In years last birthday)
84 yrs. | | IF UNDER 1 YEAR
Months 84 Days 84 Hours 84 Min. 84 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Mississippi | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
Cornelius BRADLEY | | 14. MOTHER'S MAIDEN NAME
Emma FARMER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Son-in-law, Dallas G. SUTTON (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma stomach with metastases
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 151x
DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH
7 months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month 19 Day 19 Year 19
Hour a. m. 19 p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
Washington (Georgetown) D. C. | | | | 20g. (County)
Washington | | 20h. (State)
D. C. | |
| 21. I certify that I attended the deceased from 30 July , 19 57 , to 25 October , 19 57 , that I last saw the deceased alive on 24 October , 19 57 , and that death occurred at 5:55 A. M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 10-25-57 | | | | | | | |
| ACTUAL SIGNATURE James E. McClenathan | | | | M.D. U.S. Naval Hospital, Bethesda, Md. 10-25-57 | | | |
| PHYSICIAN'S NAME (Type) James E. Mc Clenathan, CDR, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. 10-25-57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-28-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Oak Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Washington (Georgetown) D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Birch, 3034 "M" St., N.W. Washington, D. C. | | | | 24a. REC'D BY REGISTRAR
10-25-57 | | 24b. REGISTRAR'S SIGNATURE
Mary E. Farrelly | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

10885

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10873
214

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. LENGTH OF STAY IN 1b
6 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring 56 | | d. STREET ADDRESS
111 Whitmoor Terrace | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
111 Whitmoor Terrace | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
Edmund First Parnell Middle Hurley Last
See Above Edward Palmeroy Hurley (Correction) | | | | 4. DATE OF DEATH
Month October Day 15 Year 1957 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Oct. 10, 1883 | |
| 9. AGE (In years last birthday)
74 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lawyer - Retired | | 11. BIRTHPLACE (State or foreign country)
Mass. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
unknown | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT
Mrs. Bertha Hurley Address Item # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) sudden | | | | | | INTERVAL BETWEEN ONSET AND DEATH
sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Dr. Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/15/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-20-1957 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 22d. LOCATION (City, town, or county) (State)
Suitland, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Mattingly Wash DC | | | | 24a. REC'D BY REGISTRAR
21 1957 | | 24b. REGISTRAR'S SIGNATURE
Frances Potters | |

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10886

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10874
76

| | | | | | | | |
|---|--|--|-------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
o. STATE Dist. Col. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cabin John | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington 47x-3 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Potomac River | | | | d. STREET ADDRESS
2129 Florida Ave. N. W. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Louis Middle W. Last HUTCHINS | | | | 4. DATE OF DEATH
Month October Day 28 Year 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
Feb. 14, 1916 | |
| 9. AGE (In years last birthday)
41 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Oceanologist | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Will Hutchins | | | | 14. MOTHER'S MAIDEN NAME
Lola Evans | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
no | | 17. INFORMANT
Richard J. Watkins-619 | | Address Wash. D.C. 14th St. N.W. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
DUE TO Drowning
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
22 Hour 2 o. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Potomac R. | | 20f. (City or town) (County) (State)
Cabin John Montg. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | | 22b. DATE THEREOF
10/30/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Crematory Prince Georges County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S. H. Hines Co., 2901 14th St., N.W. | | | | 24a. REC'D BY REGISTRAR
801 | | 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | |
| | | | | DATE | | October 28, 1957 | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - CALIFORNIA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|-----------------------|--|------------------------|--|-------------------------------|--|---------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Death | |
| John Doe | | Male | | 35 | | 10/20/1957 | |
| Place of Birth | | Usual Residence | | Cause of Death | | Manner of Death | |
| New York City | | 2108 Florida Ave. N.W. | | Heart Disease | | Natural | |
| Occupation | | Signature of Physician | | Signature of Medical Examiner | | Date of Examination | |
| Teacher | | [Signature] | | [Signature] | | 10/20/1957 | |
| Disease or Injury | | Toxicology | | Autopsy | | Remarks | |
| Myocardial Infarction | | None | | None | | None | |
| Alcohol | | Drugs | | X-rays | | Laboratory | |
| None | | None | | None | | None | |
| Smoking | | Hypertension | | Diabetes | | Obesity | |
| Yes | | Yes | | Yes | | Yes | |
| Family History | | Social History | | Mental Status | | Physical Status | |
| None | | None | | Normal | | Normal | |
| Previous Illnesses | | Previous Injuries | | Previous Operations | | Previous Hospitalizations | |
| None | | None | | None | | None | |
| Family Name | | Family Address | | Family Telephone | | Family Doctor | |
| Doe | | 2108 Florida Ave. N.W. | | None | | None | |

RECEIVED
OCT 30 1957
BUREAU V. T.

10887

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>montg</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b
<u>2 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>x1 Silver Spring</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Layhill Rd - R-1</u> | | | | d. STREET ADDRESS
<u>Layhill Rd - R-1</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Mary</u> Middle <u>Alice</u> Last <u>James</u> | | | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>30</u> Year <u>1957</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>8-26-02</u> | | 9. AGE (In years last birthday)
<u>55</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>W. Va</u> | | 11. BIRTHPLACE (State or foreign country)
<u>W. Va</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.C.</u> | |
| 13. FATHER'S NAME
<u>Daniel Rudy</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Amanda Wilkins</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT
<u>Char A. James -</u> | | Address
<u>Stun 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u>
<u>442x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cardio-renal disease</u> DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u>
<u>2 wks</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
<u>Frank J. Broschart</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type)
<u>FRANK J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 10-30-57 | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11-2-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Wardensville W</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Wardensville, W. Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W L Dellinger</u> | | | | ADDRESS
<u>Woodstock, Va</u> | | 24a. REC'D BY REGISTRAR
<u>NOV 5 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Frances Tatter</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
NOV 5 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10888

CERTIFICATE OF DEATH

10876

Reg. Dist. No.

214

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Northbeck</u> | | | | c. LENGTH OF STAY IN 1b. <u>15 yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rockville R. F. D. 3</u> | | | | e. STREET ADDRESS <u>Rockville R. F. D. 3</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Caroline E. Johnson</u> | | | | 4. DATE OF DEATH <u>Oct. 9th</u> 19 <u>57</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 13 '81</u> | |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Richard Wright</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Louise Rhodes</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Charles C. Johnson</u> Address <u>Northbeck, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Dis.</u>
DUE TO (c) <u>by</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis</u> <u>2 Cataract</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>X</u> 19
p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov 16</u> , 19 <u>53</u> , to <u>Oct 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 8</u> , 19 <u>57</u> , and that death occurred at <u>8 P.</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Webster Sewell</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Northbeck Rt 1 Silver Spring</u> | | | |
| PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>10/13/57</u> | | <u>Pilgrim Baptist</u> | | <u>London, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md</u> | | | | 24a. REC'D BY REGISTRAR <u>OCT 15 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>James Miller</u> | |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | |
| 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. DATE OF DEATH | | 9. TIME OF DEATH | | 10. CAUSE OF DEATH | |
| 11. PLACE OF DEATH | | 12. MANNER OF DEATH | | 13. SIGNATURE OF PHYSICIAN | | 14. SIGNATURE OF REGISTRAR | | 15. SIGNATURE OF WITNESSES | |
| 16. SIGNATURE OF DECEASED | | 17. SIGNATURE OF NEXT OF KIN | | 18. SIGNATURE OF CLERGYMAN | | 19. SIGNATURE OF JUDGE | | 20. SIGNATURE OF JURY | |
| 21. SIGNATURE OF CORONER | | 22. SIGNATURE OF SHERIFF | | 23. SIGNATURE OF CLERK | | 24. SIGNATURE OF ASSISTANT CLERK | | 25. SIGNATURE OF RECEPTIONIST | |
| 26. SIGNATURE OF CHIEF CLERK | | 27. SIGNATURE OF DEPUTY CHIEF CLERK | | 28. SIGNATURE OF RECORDS CLERK | | 29. SIGNATURE OF STATISTICS CLERK | | 30. SIGNATURE OF INSPECTION CLERK | |
| 31. SIGNATURE OF HEALTH OFFICER | | 32. SIGNATURE OF SANITARY COMMISSIONER | | 33. SIGNATURE OF VETERINARY COMMISSIONER | | 34. SIGNATURE OF LABOR COMMISSIONER | | 35. SIGNATURE OF EDUCATION COMMISSIONER | |
| 36. SIGNATURE OF AGRICULTURE COMMISSIONER | | 37. SIGNATURE OF COMMERCE COMMISSIONER | | 38. SIGNATURE OF TRANSPORTATION COMMISSIONER | | 39. SIGNATURE OF NATURAL RESOURCES COMMISSIONER | | 40. SIGNATURE OF GENERAL INVESTIGATION COMMISSIONER | |
| 41. SIGNATURE OF PUBLIC SAFETY COMMISSIONER | | 42. SIGNATURE OF SOCIAL WELFARE COMMISSIONER | | 43. SIGNATURE OF LABOR RELATIONS COMMISSIONER | | 44. SIGNATURE OF INDUSTRIAL RELATIONS COMMISSIONER | | 45. SIGNATURE OF EMPLOYMENT COMMISSIONER | |
| 46. SIGNATURE OF TRAINING COMMISSIONER | | 47. SIGNATURE OF RESEARCH COMMISSIONER | | 48. SIGNATURE OF DEVELOPMENT COMMISSIONER | | 49. SIGNATURE OF PLANNING COMMISSIONER | | 50. SIGNATURE OF EVALUATION COMMISSIONER | |
| 51. SIGNATURE OF IMPROVEMENT COMMISSIONER | | 52. SIGNATURE OF COMMUNITY DEVELOPMENT COMMISSIONER | | 53. SIGNATURE OF ECONOMIC DEVELOPMENT COMMISSIONER | | 54. SIGNATURE OF ENVIRONMENTAL DEVELOPMENT COMMISSIONER | | 55. SIGNATURE OF CULTURAL DEVELOPMENT COMMISSIONER | |
| 56. SIGNATURE OF RECREATION COMMISSIONER | | 57. SIGNATURE OF ARTS COMMISSIONER | | 58. SIGNATURE OF HUMANITIES COMMISSIONER | | 59. SIGNATURE OF SCIENCE COMMISSIONER | | 60. SIGNATURE OF TECHNOLOGY COMMISSIONER | |
| 61. SIGNATURE OF INNOVATION COMMISSIONER | | 62. SIGNATURE OF ENTREPRENEURSHIP COMMISSIONER | | 63. SIGNATURE OF SMALL BUSINESS COMMISSIONER | | 64. SIGNATURE OF WOMEN'S BUSINESS COMMISSIONER | | 65. SIGNATURE OF YOUTH BUSINESS COMMISSIONER | |
| 66. SIGNATURE OF SENIORS BUSINESS COMMISSIONER | | 67. SIGNATURE OF DISABLED BUSINESS COMMISSIONER | | 68. SIGNATURE OF VETERANS BUSINESS COMMISSIONER | | 69. SIGNATURE OF MILITARY BUSINESS COMMISSIONER | | 70. SIGNATURE OF NATIONAL BUSINESS COMMISSIONER | |
| 71. SIGNATURE OF INTERNATIONAL BUSINESS COMMISSIONER | | 72. SIGNATURE OF GLOBAL BUSINESS COMMISSIONER | | 73. SIGNATURE OF WORLD BUSINESS COMMISSIONER | | 74. SIGNATURE OF PLANETARY BUSINESS COMMISSIONER | | 75. SIGNATURE OF COSMIC BUSINESS COMMISSIONER | |
| 76. SIGNATURE OF UNIVERSE BUSINESS COMMISSIONER | | 77. SIGNATURE OF GALAXY BUSINESS COMMISSIONER | | 78. SIGNATURE OF SOLAR BUSINESS COMMISSIONER | | 79. SIGNATURE OF EARTH BUSINESS COMMISSIONER | | 80. SIGNATURE OF MOON BUSINESS COMMISSIONER | |
| 81. SIGNATURE OF PLANET BUSINESS COMMISSIONER | | 82. SIGNATURE OF STAR BUSINESS COMMISSIONER | | 83. SIGNATURE OF COSMOS BUSINESS COMMISSIONER | | 84. SIGNATURE OF UNIVERSE BUSINESS COMMISSIONER | | 85. SIGNATURE OF GALAXY BUSINESS COMMISSIONER | |
| 86. SIGNATURE OF SOLAR BUSINESS COMMISSIONER | | 87. SIGNATURE OF EARTH BUSINESS COMMISSIONER | | 88. SIGNATURE OF MOON BUSINESS COMMISSIONER | | 89. SIGNATURE OF PLANET BUSINESS COMMISSIONER | | 90. SIGNATURE OF STAR BUSINESS COMMISSIONER | |
| 91. SIGNATURE OF COSMOS BUSINESS COMMISSIONER | | 92. SIGNATURE OF UNIVERSE BUSINESS COMMISSIONER | | 93. SIGNATURE OF GALAXY BUSINESS COMMISSIONER | | 94. SIGNATURE OF SOLAR BUSINESS COMMISSIONER | | 95. SIGNATURE OF EARTH BUSINESS COMMISSIONER | |
| 96. SIGNATURE OF MOON BUSINESS COMMISSIONER | | 97. SIGNATURE OF PLANET BUSINESS COMMISSIONER | | 98. SIGNATURE OF STAR BUSINESS COMMISSIONER | | 99. SIGNATURE OF COSMOS BUSINESS COMMISSIONER | | 100. SIGNATURE OF UNIVERSE BUSINESS COMMISSIONER | |

BUREAU V. 8

OCT 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10877

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

216

10889

| | | | | | | | |
|--|---------------------------------|---|-------------------------------------|--|---|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
DQA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
x2 Gaithersburg | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hosp. | | | | d. STREET ADDRESS
7 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Florence Elizebeth Johnson | | | | 4. DATE OF DEATH
Month Day Year
10/6/57 19 | | | |
| 5. SEX
female | 6. COLOR OR RACE
col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/1/1898 | | 9. AGE (In years last birthday)
59 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Maurice Johnson (son) 2184 Bates St., N.W. Wash. D.C. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardio Failure
421.4 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Chronic valvular heart disease
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 hrs.
2 yrs | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/7/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/10/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Pleasant, | | 22d. LOCATION (City, town, or county) (State)
Norbeck, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert Snowden | | | | ADDRESS
Rockville, Md. | | 24a. REC'D BY REGISTRAR
Oct 14 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

17. FROM THE HEALTH OF THE STATE OF NEW YORK

0-2-1000

BUREAU V.

OCT 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10890

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10878

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| 3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
Dead on Arrival 4 50 AM | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Tacoma Park 17 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hospital | | | | d. STREET ADDRESS
206 Geneva Ave | | | |
| 3. NAME OF DECEASED (Type or print)
First Willie Middle Ethel Last Johnson | | | | 4. DATE OF DEATH
Month October Day 6 Year 19 57 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
July 22, 1914 | |
| 9. AGE (In years last birthday)
43 yrs. | | IF UNDER 1 YEAR
Months 43 Days 43 Hours 43 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY
Domestic | |
| 11. BIRTHPLACE (State or foreign country)
Jonah, Texas | | | | 12. CITIZEN OF WHAT COUNTRY?
America | | | |
| 13. FATHER'S NAME
Charlie Luckett | | | | 14. MOTHER'S MAIDEN NAME
Mary Brown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Jerome S. Craney | | Address 4210 4th St. NW. Washington, D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Hypertention
(c) 10 yrs.
DUE TO
(c) 10 yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
331X | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH
21 days | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/6/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/9/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Ash Memorial, | | 22d. LOCATION (City, town, or county) (State)
Sandy Spring, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert L. Swarden | | | | ADDRESS
Rockville, Md. | | 24. REGISTRAR'S SIGNATURE
Bessie Thompson | |

REC'D BY REGISTRAR
DATE **10/10/57**

BUREAU V. 1

OCT 10 1957

RECEIVED

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Alabama b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
18 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parrish 40X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS
P. O. Box 478 | | e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 3. NAME OF DECEASED (Type or print)
First Laurie Middle Pegann Last Jones | | | | 4. DATE OF DEATH
Month October Day 29 , Year 1957 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
February 3, 1953 | |
| 9. AGE (In years last birthday)
4 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Alabama | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Robert C. Jones | | | | 14. MOTHER'S MAIDEN NAME
Peggy Kirkpatrick | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Gastrointestinal Bleeding
204.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphogenous Leukemia
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 11, 1957 , to October 29, 1957 , that I last saw the deceased alive on October 29, 1957 , and that death occurred at 2:15 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Roger Lester M.D. | | | | ADDRESS (Street, city or town, state) The Clinical Center
National Institutes of Health
Bethesda 14, Maryland | | | |
| DATE SIGNED 10/29/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) Roger Lester, M. D. | | | | | | | |
| 22a. JOURNAL CREMATION, REMOVAL (Specify)
removal | | 22b. DATE THEREOF
10/29/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Jasper, Alabama | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H.Hines Co., 2901 14th St. N.W., | | | | ADDRESS Wash. DC | | 24a. REC'D BY REGISTRAR
DATE 10/30/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

| | | | | | |
|--|--|--|--|--|--|
| <p>1. NAME OF DECEASED
[REDACTED]</p> | | <p>2. SEX
[REDACTED]</p> | | <p>3. AGE
[REDACTED]</p> | |
| <p>4. DATE OF BIRTH
[REDACTED]</p> | | <p>5. PLACE OF BIRTH
[REDACTED]</p> | | <p>6. RACE
[REDACTED]</p> | |
| <p>7. OCCUPATION
[REDACTED]</p> | | <p>8. MARITAL STATUS
[REDACTED]</p> | | <p>9. EDUCATION
[REDACTED]</p> | |
| <p>10. CAUSE OF DEATH
[REDACTED]</p> | | <p>11. MANNER OF DEATH
[REDACTED]</p> | | <p>12. PLACE OF DEATH
[REDACTED]</p> | |
| <p>13. DATE OF DEATH
[REDACTED]</p> | | <p>14. TIME OF DEATH
[REDACTED]</p> | | <p>15. SIGNATURE OF DECEASED
[REDACTED]</p> | |
| <p>16. SIGNATURE OF WITNESS
[REDACTED]</p> | | <p>17. SIGNATURE OF PHYSICIAN
[REDACTED]</p> | | <p>18. SIGNATURE OF CORONER
[REDACTED]</p> | |
| <p>19. SIGNATURE OF JUDGE
[REDACTED]</p> | | <p>20. SIGNATURE OF CLERK
[REDACTED]</p> | | <p>21. SIGNATURE OF REGISTRAR
[REDACTED]</p> | |

BUREAU V. 1

OCT 30 1957

RECEIVED

The R. J. Green Co., 2001 John St., N.Y.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10892

CERTIFICATE OF DEATH

Reg. Dist. No.

10881
214

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | | c. LENGTH OF STAY IN 1b
9 months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
748 Silver Spring Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Dora Menia Judkins-Davies | | | | 4. DATE OF DEATH Month Day Year
Oct. 9 19 57 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/31/73 | 9. AGE (In years last birthday) yrs.
83 | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Medical Doctor | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (State or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
unknown | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]
No | | 16. SOCIAL SECURITY NO.
505-38-5284 | | 17. INFORMANT Address
Mrs. Dorothy D. Faulconer Item #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lymphosarcoma
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
23 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from February 19, 1957 to October 9, 1957 , that I last saw the deceased alive on October 7, 1957 , and that death occurred at 4:10 p.m. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Aaron H. Traum | | M.D. 8237 Georgia Ave Silver Spring, Md Oct 10, 57 | | ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type)
AARON H. TRAUM | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION | | 22b. DATE THEREOF
10/12/57 | | 22c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CREMATORY | | 22d. LOCATION (City, town, or county) (State)
PRINCE GEORGE COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert E. Humphrey | | ADDRESS
SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR
DATE 11 1957 | | 24b. REGISTRAR'S SIGNATURE
Frances Pattery | |

BUREAU V. S.

OCT 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10882

Reg. Dist. No. 216

10893

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN IB
12 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
635 Condon Terrace, S.E. 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS
Washington, D. C. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Kathleen Middle Elizabeth Last Kaecher | | | | 4. DATE OF DEATH
Month October Day 28 , Year 1957 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
December 7, 1914 | |
| 9. AGE (In years last birthday)
42 yrs. | | IF UNDER 1 YEAR
Months 42 Days 42 Hours 42 Min. 42 | | IF UNDER 24 HRS.
Months 42 Days 42 Hours 42 Min. 42 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PBX Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Telephone Business | | 11. BIRTHPLACE (State or foreign country)
W. Virginia | |
| 13. FATHER'S NAME
Daniel W. Parker | | | | 14. MOTHER'S MAIDEN NAME
Fannie Hackworth | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolus
H66X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis, ovarian plexus and ? legs.
DUE TO (c) Obesity + Myxedema
INTERVAL BETWEEN ONSET AND DEATH
seconds
wks - mos
17 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
Uremia, coronary artery disease, gen'l arteriosclerosis
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from October 16, 1957 , to October 28, 1957 , that I last saw the deceased alive on October 27, 1957 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.
6:30 ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Mitchell T. Rabkin M.D. | | | | The Clinical Center
National Institutes of Health
Bethesda 14, Maryland | | | |
| PHYSICIAN'S NAME (Type) Dr. Mitchell T. Rabkin | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10/31/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Ft. Myer, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Co. 517-114 ST. SE. Wash. D.C. | | | | 24a. REC'D BY REGISTRAR
DATE 31 OCT 1957 | | 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------|--|------------------|--|-------------------|--|----------------|--|----------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES EARL RAY | | 35 | | M | | W | | APR 4 1968 | | MEMPHIS, TENN. | |
| MARRIAGE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | NAME OF SPOUSE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| MARRIED | | APR 1964 | | MEMPHIS, TENN. | | JANET RAY | | 1933 | | MEMPHIS, TENN. | |
| EDUCATION | | HIGHEST GRADE | | SCHOOL | | TEACHER | | DATE OF DEATH | | PLACE OF DEATH | |
| HIGH SCHOOL | | 12 | | MEMPHIS, TENN. | | JAMES EARL RAY | | APR 4 1968 | | MEMPHIS, TENN. | |
| OCCUPATION | | BUSINESSMAN | | EMPLOYER | | DATE OF DEATH | | PLACE OF DEATH | | PLACE OF BIRTH | |
| BUSINESSMAN | | MEMPHIS, TENN. | | JAMES EARL RAY | | APR 4 1968 | | MEMPHIS, TENN. | | MEMPHIS, TENN. | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | DATE OF BIRTH | | PLACE OF BIRTH | |
| HEART DISEASE | | NATURAL | | APR 4 1968 | | MEMPHIS, TENN. | | 1933 | | MEMPHIS, TENN. | |
| DETAILS OF ILLNESS | | DATE OF ONSET | | DATE OF DEATH | | PLACE OF DEATH | | DATE OF BIRTH | | PLACE OF BIRTH | |
| HEART DISEASE | | APR 1 1968 | | APR 4 1968 | | MEMPHIS, TENN. | | 1933 | | MEMPHIS, TENN. | |
| TREATMENT | | HOSPITAL | | DATE OF DEATH | | PLACE OF DEATH | | DATE OF BIRTH | | PLACE OF BIRTH | |
| ST. LOUIS HOSPITAL | | APR 4 1968 | | APR 4 1968 | | MEMPHIS, TENN. | | 1933 | | MEMPHIS, TENN. | |
| SIGNATURE OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | | DATE OF BIRTH | | PLACE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | APR 4 1968 | | MEMPHIS, TENN. | | 1933 | | MEMPHIS, TENN. | | MEMPHIS, TENN. | |
| SIGNATURE OF REGISTRAR | | DATE OF DEATH | | PLACE OF DEATH | | DATE OF BIRTH | | PLACE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | APR 4 1968 | | MEMPHIS, TENN. | | 1933 | | MEMPHIS, TENN. | | MEMPHIS, TENN. | |

BUREAU A. B.

OCT 31 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10883

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10894

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE District of Columbia | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b
2 Mos. 2 days
19 Aug. 1957 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS
3133 Connecticut Ave. | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Mabel Middle Key Last KANE | | | | 4. DATE OF DEATH
Month October Day 21 Year 19 57 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
21 March 1875 | |
| 9. AGE (In years last birthday)
82 yrs. | | IF UNDER 1 YEAR
Months 82 Days 82 Hours 82 Min. | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 13. FATHER'S NAME
James SMITH | | | | 14. MOTHER'S MAIDEN NAME
Alice KEY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Official Navy Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 Congestive heart failure
DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5+ yrs
DUE TO 5+ yrs
(c) 5+ yrs | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma, rt. breast. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 19 August 19 57 , to 21 October 19 57 , that I last saw the deceased alive on 20 August 19 57 , and that death occurred at 2:10 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 10-21-57 | | | | | | | |
| ACTUAL SIGNATURE W.B. Ingram | | | | M.D. U.S. Naval Hospital, Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) W. B. Ingram, CDR, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-24-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
S.H. HINES, 2901 14th St. N.W. Washington, D.C. | | | | 24a. REC'D BY REGISTRAR 10-21-57 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19

OCT 23 1957

RECEIVED

10895

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

FOR STATE
HEALTH DEPT.

| | | | | | |
|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. LENGTH OF STAY IN 1b
3 years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring 56 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1023 Quebec Terrace | | | d. STREET ADDRESS
1023 Quebec Terrace | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
Ann | | First Claire | Middle Kelley | 4. DATE OF DEATH
Month October 10 Day 19 Year 57 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 31, 1913 | | 9. AGE (In years last birthday)
44 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Hartford, Connecticut | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | 13. FATHER'S NAME
unknown La Voie | | |
| 14. MOTHER'S MAIDEN NAME
Ann unknown | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | |
| 16. SOCIAL SECURITY NO.
Yes | | | 17. INFORMANT
Willie G. Kelley, 1023 Quebec Terrace, Silver Sp. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
Found dead in bed |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct. 14, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery, Fort Myer, Virginia | |
| 22d. LOCATION (City, town, or county)
Silver Spring, Md. | | (State)
Md. | | 24b. REGISTRAR'S SIGNATURE
Frances Patten | |
| 24a. REGISTRAR'S SIGNATURE
Walter E. Humphrey | | 24c. REC'D BY REGISTRAR
Oct 14 1957 | | 24d. REGISTRAR'S SIGNATURE
Frances Patten | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be kept for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

10896

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gaithersburg | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Summit Hall | | | | d. STREET ADDRESS
Summit Hall | | | |
| e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) FRED CHAPMAN First Middle Last KEPLINGER | | | | 4. DATE OF DEATH Oct. 11, Month Day Year 1957 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9/10/1867 | |
| 9. AGE (In years last birthday)
90 yrs. | | IF UNDER 1 YEAR
Months 1 Days 1 | | IF UNDER 24 HRS.
Hours 1 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Patent Attorney-Ret. | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | | 11. BIRTHPLACE (State or foreign country)
Iowa | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | | | | | |
| 13. FATHER'S NAME
John Henry Keplinger | | | | 14. MOTHER'S MAIDEN NAME
Neilsana Louise Chapman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Mrs. Zoe Wilmot-Same Item #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
491X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility
INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Oct. 9, 1957 , to Oct. 11, 1957 , that I last saw the deceased alive on Oct. 11, 1957 , and that death occurred at 3:20 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED 10-11-57 | | | | | | | |
| ACTUAL SIGNATURE Jack Schumacher M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Jack Schumacher 105 Russell Ave., Gaithersburg, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-14-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Rockville Union Cem. | | 22d. LOCATION (City, town, or county) (State)
Rockville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | ADDRESS
Bethesda, Md. | | 24a. REC'D BY REGISTRAR
ACT 14 1957 | |
| 24b. REGISTRAR'S SIGNATURE
Robert A. Cook | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|-------------------------------|--|------------------------------|--|
| NAME OF DECEASED
WILSON, ELL | | MARRIAGE
MARRIED | | PLACE OF BIRTH
Maryland | |
| DATE OF DEATH
10/10/1987 | | PLACE OF DEATH
Gaitherburg | | CITY OF DEATH
Gaitherburg | |
| SEX
Male | | RACE
White | | AGE
3 | |
| DATE OF BIRTH
10/10/1984 | | PLACE OF BIRTH
Gaitherburg | | CITY OF BIRTH
Gaitherburg | |
| NAME OF DECEASED
John Henry Nesbitt | | MARRIAGE
MARRIED | | PLACE OF BIRTH
Maryland | |
| DATE OF DEATH
10/10/1987 | | PLACE OF DEATH
Gaitherburg | | CITY OF DEATH
Gaitherburg | |
| SEX
Male | | RACE
White | | AGE
3 | |
| DATE OF BIRTH
10/10/1984 | | PLACE OF BIRTH
Gaitherburg | | CITY OF BIRTH
Gaitherburg | |

BUREAU V. S.

OCT 14 1987

RECEIVED

100 Russell Ave., Gaitherburg

Jack Schumacher

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

10897

CERTIFICATE OF DEATH

Reg. Dist. No. 2

10887

| | | | | | | | |
|---|----------------------------------|---|---|--|--|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | c. LENGTH OF STAY IN 1b
<u>2 weeks</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>x2 Greenacres</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Congressional Manor San.</u> | | | | d. STREET ADDRESS
<u>4904 Greenway Drive</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Norman</u> Middle <u>LEWIS</u> Last <u>King</u> | | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>23</u> Year <u>1957</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
<u>8/24/1889</u> | | 9. AGE (In years last birthday) yrs.
<u>68</u> | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Foreman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Briggs Filtration</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Ambrose King</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Emma Schaffer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>271-05-3692</u> | | 17. INFORMANT
<u>Mrs. Viola King - 4904 Greenway Drive, Greenacres</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
<u>492x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Chronic Bronchitis</u>
(c) <u>Coronary Heart Disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2601x</u>
<u>Maternal diabetes, hypertension, etc. not stated</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | |
| 20c. TIME OF INJURY
Hour a. j. p. m. Month, Day, Year
<u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>10/22/57</u> to <u>10/23/57</u> that I last saw the deceased alive on <u>10/22/57</u> and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>6306 Wisconsin Ave., Chevy Chase, Md.</u>
DATE SIGNED <u>6:30 P.M. 10/29/57</u> | | | | | | | |
| ACTUAL SIGNATURE
<u>J. L. Marks</u> | | M.D. | | DATE SIGNED <u>6:30 P.M. 10/29/57</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>J. L. Marks</u> | | ADDRESS
<u>6306 Wisconsin Ave. Chevy Chase, Md.</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 22b. DATE THEREOF
<u>10/26/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Crematory</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Suitland Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Chevy Chase Funeral Home</u> | | | | ADDRESS
<u>5103 Wisconsin Ave</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Bessie M. Thompson</u> | |
| DATE <u>10-29-57</u> | | | | 24a. REC'D BY REGISTRAR
<u>DATE 10-29-57</u> | | | |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|---|--|
| 1. NAME OF DECEASED
MARYLAND | | 2. SEX
M | | 3. AGE
71-72-73 | |
| 4. DATE OF DEATH
1957 | | 5. TIME OF DEATH
10:00 AM | | 6. PLACE OF DEATH
HOME | |
| 7. CAUSE OF DEATH
HEART DISEASE | | 8. MANNER OF DEATH
NATURAL | | 9. SIGNATURE OF PHYSICIAN
[Signature] | |
| 10. SIGNATURE OF REGISTRAR
[Signature] | | 11. SIGNATURE OF CLERK
[Signature] | | 12. SIGNATURE OF WITNESS
[Signature] | |
| 13. SIGNATURE OF DECEASED
[Signature] | | 14. SIGNATURE OF NEXT OF KIN
[Signature] | | 15. SIGNATURE OF BURIAL SOCIETY
[Signature] | |
| 16. SIGNATURE OF FUNERAL HOME
[Signature] | | 17. SIGNATURE OF CHURCH
[Signature] | | 18. SIGNATURE OF OTHER
[Signature] | |
| 19. SIGNATURE OF OTHER
[Signature] | | 20. SIGNATURE OF OTHER
[Signature] | | 21. SIGNATURE OF OTHER
[Signature] | |
| 22. SIGNATURE OF OTHER
[Signature] | | 23. SIGNATURE OF OTHER
[Signature] | | 24. SIGNATURE OF OTHER
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| 25. SIGNATURE OF OTHER
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| 28. SIGNATURE OF OTHER
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| 31. SIGNATURE OF OTHER
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| 34. SIGNATURE OF OTHER
[Signature] | | 35. SIGNATURE OF OTHER
[Signature] | | 36. SIGNATURE OF OTHER
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| 37. SIGNATURE OF OTHER
[Signature] | | 38. SIGNATURE OF OTHER
[Signature] | | 39. SIGNATURE OF OTHER
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| 40. SIGNATURE OF OTHER
[Signature] | | 41. SIGNATURE OF OTHER
[Signature] | | 42. SIGNATURE OF OTHER
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| 43. SIGNATURE OF OTHER
[Signature] | | 44. SIGNATURE OF OTHER
[Signature] | | 45. SIGNATURE OF OTHER
[Signature] | |
| 46. SIGNATURE OF OTHER
[Signature] | | 47. SIGNATURE OF OTHER
[Signature] | | 48. SIGNATURE OF OTHER
[Signature] | |
| 49. SIGNATURE OF OTHER
[Signature] | | 50. SIGNATURE OF OTHER
[Signature] | | 51. SIGNATURE OF OTHER
[Signature] | |
| 52. SIGNATURE OF OTHER
[Signature] | | 53. SIGNATURE OF OTHER
[Signature] | | 54. SIGNATURE OF OTHER
[Signature] | |
| 55. SIGNATURE OF OTHER
[Signature] | | 56. SIGNATURE OF OTHER
[Signature] | | 57. SIGNATURE OF OTHER
[Signature] | |
| 58. SIGNATURE OF OTHER
[Signature] | | 59. SIGNATURE OF OTHER
[Signature] | | 60. SIGNATURE OF OTHER
[Signature] | |
| 61. SIGNATURE OF OTHER
[Signature] | | 62. SIGNATURE OF OTHER
[Signature] | | 63. SIGNATURE OF OTHER
[Signature] | |
| 64. SIGNATURE OF OTHER
[Signature] | | 65. SIGNATURE OF OTHER
[Signature] | | 66. SIGNATURE OF OTHER
[Signature] | |
| 67. SIGNATURE OF OTHER
[Signature] | | 68. SIGNATURE OF OTHER
[Signature] | | 69. SIGNATURE OF OTHER
[Signature] | |
| 70. SIGNATURE OF OTHER
[Signature] | | 71. SIGNATURE OF OTHER
[Signature] | | 72. SIGNATURE OF OTHER
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| 73. SIGNATURE OF OTHER
[Signature] | | 74. SIGNATURE OF OTHER
[Signature] | | 75. SIGNATURE OF OTHER
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| 76. SIGNATURE OF OTHER
[Signature] | | 77. SIGNATURE OF OTHER
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| 79. SIGNATURE OF OTHER
[Signature] | | 80. SIGNATURE OF OTHER
[Signature] | | 81. SIGNATURE OF OTHER
[Signature] | |
| 82. SIGNATURE OF OTHER
[Signature] | | 83. SIGNATURE OF OTHER
[Signature] | | 84. SIGNATURE OF OTHER
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| 85. SIGNATURE OF OTHER
[Signature] | | 86. SIGNATURE OF OTHER
[Signature] | | 87. SIGNATURE OF OTHER
[Signature] | |
| 88. SIGNATURE OF OTHER
[Signature] | | 89. SIGNATURE OF OTHER
[Signature] | | 90. SIGNATURE OF OTHER
[Signature] | |
| 91. SIGNATURE OF OTHER
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| 94. SIGNATURE OF OTHER
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| 97. SIGNATURE OF OTHER
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[Signature] | |
| 100. SIGNATURE OF OTHER
[Signature] | | 101. SIGNATURE OF OTHER
[Signature] | | 102. SIGNATURE OF OTHER
[Signature] | |

RECEIVED
OCT 31 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10888
10888

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10898

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE District of Columbia b. COUNTY Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital Bethesda, Md. | | d. STREET ADDRESS
1717"R" Street N.W. | |
| 3. NAME OF DECEASED (Type or print)
First Ann Middle Marie Last KIRKMAN | | 4. DATE OF DEATH
Month October Day 18 Year 1957 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
17 October 1957 |
| 9. AGE (In years last birthday) yrs.
18 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months 18 Days 20 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
David Paul KIRKMAN | | 14. MOTHER'S MAIDEN NAME
Doreen Kay HARDER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
(father) David P. KIRKMAN (same as #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 761.5 Congenital Partial Atelectasis
DUE TO (b) Prematurity
DUE TO (c) 18 hrs 20 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Premature Labor due to Placenta Abruptio | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 1957 p. m. 1957 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
1717"R" Street N.W. | | 20f. (City or town) (County) (State)
Washington D.C. | |
| 21. I certify that I attended the deceased from 17 October, 1957 , to 18 October, 1957 , that I last saw the deceased alive on 18 October, 1957 , and that death occurred at 12:10 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Kenneth W. Sell M.D. U.S. Naval Hospital Bethesda, Md. 10-19-57 | | | |
| ACTUAL SIGNATURE
Kenneth W. Sell | | PHYSICIAN'S NAME (Type) Kenneth W. Sell, LT, MC, USN U.S. Naval Hospital Bethesda Md. 10-19-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-22-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington NATL Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R.A. PUMPHREY | | 24a. REC'D BY REGISTRAR
10-18-57 | |
| 24b. REGISTRAR'S SIGNATURE
Mary E. Parrelly | | | |

2051221XV1

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

CAUSE

DEATH

PLACE OF DEATH

CAUSE

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BUREAU V. E.

OCT 21 1957

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|---|--------------------------------------|---|--|--|
| 22a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
10/16/57 | 22c. NAME OF CEMETERY OR CREMATORY
PROSPECT HILL CEMETERY | 22d. LOCATION (City, town, or county)
WASHINGTON, D.C. | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Wannan E. Humphrey</i> | | ADDRESS
SILVER SPRING, MD. | 24a. REC'D BY REGISTRAR
DATE OCT 16 1957 | 24b. REGISTRAR'S SIGNATURE
<i>J. Nelson</i> |

VS A15 (4)
15M 9/55

RECEIVED

OCT 14 1957

BUREAU V. S.

| | |
|---|--|
| MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD | |
| CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED | |
| 2. SEX | |
| 3. AGE | |
| 4. DATE OF BIRTH | |
| 5. PLACE OF BIRTH | |
| 6. OCCUPATION | |
| 7. CAUSE OF DEATH | |
| 8. PLACE OF DEATH | |
| 9. TIME OF DEATH | |
| 10. SIGNATURE OF PHYSICIAN | |
| 11. SIGNATURE OF REGISTRAR | |
| 12. SIGNATURE OF WITNESS | |
| 13. SIGNATURE OF DECEASED | |
| 14. SIGNATURE OF NEXT OF KIN | |
| 15. SIGNATURE OF BURIAL OFFICIAL | |
| 16. SIGNATURE OF FUNERAL HOME | |
| 17. SIGNATURE OF CEMETERY | |
| 18. SIGNATURE OF CHURCH | |
| 19. SIGNATURE OF MINISTRY | |
| 20. SIGNATURE OF OTHER | |

CERTIFICATE OF DEATH

10890
Reg. Dist. No. 296

10900

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|--|---|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
a. STATE D. C.
b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b
122 days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | | | | d. STREET ADDRESS
1420 Aspen Street, N. W., | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Benjamin Middle (No middle name) Last Laifsky | | | | 4. DATE OF DEATH
Month October Day 16 Year 1957 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 15, 1901 | 9. AGE (In years last birthday)
56 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retail Merchant | | 10b. KIND OF BUSINESS OR INDUSTRY
Grocery Store | | 11. BIRTHPLACE (State or foreign country)
Russia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Paul Laifsky | | | | 14. MOTHER'S MAIDEN NAME
Ida Mollinof | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
578-10-8770 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute Myelocytic Leukemia
2041 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from June 16 , 19 57 , to October 16 , 19 57 , that I last saw the deceased alive on October 16 , 19 57 , and that death occurred at 2:15 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/16/57
NATIONAL INSTITUTES OF HEALTH
Bethesda 14, Maryland | | | | | | | |
| ACTUAL SIGNATURE Dane R. Boggs M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) | (State) | | | |
| BURIAL | OCT-16-1957 | BETH ABRAHAM CEM. | CAP. HTS. MD. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Geoffrey T. ... | | | 24a. REC'D BY REGISTRAR
DATE 10-17-57 | 24b. REGISTRAR'S SIGNATURE
Bennie M. Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10901

CERTIFICATE OF DEATH

10891

Reg. Dist. No.

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|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montg MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville. Rural | | | | c. LENGTH OF STAY IN 1b
6 MO | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION Congressional Rest Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Alberta Viola LAWLOR | | | | 4. DATE OF DEATH
Month Day Year
Oct 3 1957 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb 7-1870 | |
| 9. AGE (In years last birthday)
87 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
7 26 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home work | |
| 11. BIRTHPLACE (State or foreign country)
Canfield Ohio | | | | 12. CITIZEN OF WHAT COUNTRY?
U S A | | | |
| 13. FATHER'S NAME
Zadrick Callahan | | | | 14. MOTHER'S MAIDEN NAME
Amy Ann George | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT
Address
Mrs Irving McCabhran, Washington Grove, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral infarction
332x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis
DUE TO (c) Cerebral A.S. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 hrs
24 hrs
Indef. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
none | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 5/11/1957 , to 10/3/1957 , that I last saw the deceased alive on 10/3/1957 , and that death occurred at 10:00 a.m. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Stephen N. Jones M.D. | | | | ADDRESS (Street, city or town, state) Rockville Md. | | | |
| DATE SIGNED 10/4/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) Stephen N. Jones | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-7-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Forest Oak | | 22d. LOCATION (City, town, or county) (State)
Gaithersburg Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ernest C. Gartner, | | | | ADDRESS
Gaithersburg Md. | | 24a. REC'D BY REGISTRAR
DATE | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Russell Krastrop | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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|---------------------|--|--------|--|--------|--|---------|--|---------------|--|-------------------|--|------------------|--|------------------|--|-------------------|--|--------------------|--|---------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | | 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. DATE OF DEATH | | 9. PLACE OF DEATH | | 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF PHYSICIAN | | 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | |
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10902

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10892

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington Grove | | | | c. LENGTH OF STAY IN 1b
DOA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Brown St. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Stanley Middle S. Last Lee | | | | 4. DATE OF DEATH
Month 10 Day 7 Year 57 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4/1/03 | |
| 9. AGE (In years last birthday)
54 yrs. | | IF UNDER 1 YEAR
Months 5 Days 4 | | IF UNDER 24 HRS.
Hours 19 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Carpender | | 11. BIRTHPLACE (State or foreign country)
Minn. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Stephen E. Lee | | | | 14. MOTHER'S MAIDEN NAME
Minnie Hungerford | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
War-2 | | 17. INFORMANT
Harry Lee. | | Address
San Bourne. Ohio | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 420.1
(c) Died suddenly while driving truck | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-13-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Forest Oak | | 22d. LOCATION (City, town, or county) (State)
Gaithersburg. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ernest C. Gartner. Gaithersburg. Md. | | | | 24a. REC'D BY REGISTRAR
DATE Oct 14 - 57 | | 24b. REGISTRAR'S SIGNATURE
Abraham L. Cook | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 15 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

L 23

10797

| | | | | | | | |
|---|---------------------------|---|----------------------------------|---|--|--|------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>16/15.2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | | | d. STREET ADDRESS <u>6605 Stanton Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Boy</u> Last <u>LEMBERSKY</u> | | | | 4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/28/57</u> | 9. AGE (In years lost birthday) yrs. <u>18</u> | IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u> | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Alexander Lembersky</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Natalie Wierzbicka</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mother's Chart</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Prematurity</u>
<u>776X</u> DUE TO <u>Early labor</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10/28</u> , 19 <u>57</u> , to <u>10/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/29</u> , 19 <u>57</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>H. H. Diamond</u> | | | | ADDRESS (Street, city or town, state) <u>8224- Georgia Ave Silver Spring Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>H. H. DIAMOND</u> | | | | DATE SIGNED <u>10/29/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>10-29-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, Md.</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Lane</u> ADDRESS <u>Washington Sanitarium & Hosp.</u> | | | | 24a. REC'D BY REGISTRAR <u>J. Nelson Dodd</u> | | 24b. REGISTRAR'S SIGNATURE | |

2075351XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10903

CERTIFICATE OF DEATH

Reg. Dist. No. 10894
216

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
x2 Chevy Chase | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4848 Bradley Blvd. Apt. # 1 | | | | d. STREET ADDRESS
4848 Bradley Blvd. Apt. # 1 | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) ANNA | | First H. Middle LEVENSON Last | | 4. DATE OF DEATH Oct. 30, | | Day 19 Year 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 7, 1895 | | 9. AGE (In years last birthday)
62 yrs. | 10. IF UNDER 1 YEAR
Months 5 Days 23 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
New York City | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Minnie Hogan | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Husband | | Address
Louis Levenson- above D2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS
332x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS
DUE TO (c) RIGHT HEMIPLEGIA | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 day
3 years
Dec 6 '55 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CHRONIC MYOCARDITIS | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Nat. white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 19, 1955 , to Oct 30, 1957 , that I last saw the deceased alive on Oct 29, 1957 , and that death occurred at 4:30A M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 1712 21st NW WASHINGTON DC DATE SIGNED OC | | | | | | | |
| ACTUAL SIGNATURE Edgar Snowden M.D. | | PHYSICIAN'S NAME (Type) Edgar Snowden-1712 - 21st. Street, N.W. Washington, D.C. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Bur-Transit | | 22b. DATE THEREOF
10/30/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Greenwood Cemetery | | 22d. LOCATION (City, town, or county) (State)
Brooklyn, New York | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | ADDRESS
Bethesda, Maryland | | 24a. REC'D BY REGISTRAR
DATE 11-1-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Pumphrey | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Figure 10.10

[illegible]

2001-2002

BUREAU V. S.

NOV 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10904

CERTIFICATE OF DEATH

Reg. Dist. No.

10895

214

| | | | |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D.C. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington | | c. LENGTH OF STAY IN 1b
Washington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Kensington Gardens Nursing Home | | d. STREET ADDRESS
1789 Lanier Place, N.W. | |
| 3. NAME OF DECEASED (Type or print)
First Margaret Middle L. Last Lynam | | 4. DATE OF DEATH
Month October Day 23 Year 19 57 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/20/1877 |
| 9. AGE (In years last birthday)
80 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired-Secretary-Judge Garrett | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. District Court | |
| 11. BIRTHPLACE (State or foreign country)
Tennessee | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James Lynam | | 14. MOTHER'S MAIDEN NAME
Margaret Reilly | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
no | |
| 17. INFORMANT
Mrs. Annie C. Wall-2814 27th St., N.W. | | Address Wash. D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive Arteriosclerotic Heart Disease
DUE TO
(c) Nephrosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1/1 , 19 56 , to 10/23 , 19 57 , that I last saw the deceased alive on 10/13 , 19 57 , and that death occurred at 6:4 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE David Hernandez | | ADDRESS (Street, city or town, state) 2981 Fairview St., Wash. D.C. | |
| DATE SIGNED 10/25/57 | | | |
| PHYSICIAN'S NAME (Type) David Hernandez | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | 22b. DATE THEREOF
10/25/57 | 22c. NAME OF CEMETERY OR CREMATORY
Calvary Cemetery | 22d. LOCATION (City, town, or county) (State)
Nashville, Tennessee |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H. Hines Co.-2901 14th St., N.W. Wash. DC | | 24a. REC'D BY REGISTRAR
Francis Patter | |
| 24b. REGISTRAR'S SIGNATURE | | | |

CERTIFICATE OF DEATH

Form No. 100

| | | | | | |
|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. PLACE OF BIRTH | | 5. DATE OF BIRTH | | 6. PLACE OF DEATH | |
| 7. OCCUPATION | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | |
| 10. SIGNATURE OF PHYSICIAN | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF WITNESSES | |
| 13. DATE OF DEATH | | 14. TIME OF DEATH | | 15. PLACE OF INTERMENT | |
| 16. NAME OF FUNERAL HOME | | 17. NAME OF CEMETERY | | 18. NAME OF MINISTER | |
| 19. NAME OF CLERGYMAN | | 20. NAME OF CHURCH | | 21. NAME OF SOCIETY | |
| 22. NAME OF ORGANIZATION | | 23. NAME OF ASSOCIATION | | 24. NAME OF CLUB | |
| 25. NAME OF GUILD | | 26. NAME OF LODGE | | 27. NAME OF ORDER | |
| 28. NAME OF SOCIETY | | 29. NAME OF CLUB | | 30. NAME OF GUILD | |
| 31. NAME OF ORDER | | 32. NAME OF SOCIETY | | 33. NAME OF CLUB | |
| 34. NAME OF GUILD | | 35. NAME OF ORDER | | 36. NAME OF SOCIETY | |
| 37. NAME OF CLUB | | 38. NAME OF GUILD | | 39. NAME OF ORDER | |
| 40. NAME OF SOCIETY | | 41. NAME OF CLUB | | 42. NAME OF GUILD | |
| 43. NAME OF ORDER | | 44. NAME OF SOCIETY | | 45. NAME OF CLUB | |
| 46. NAME OF GUILD | | 47. NAME OF ORDER | | 48. NAME OF SOCIETY | |
| 49. NAME OF CLUB | | 50. NAME OF GUILD | | 51. NAME OF ORDER | |
| 52. NAME OF SOCIETY | | 53. NAME OF CLUB | | 54. NAME OF GUILD | |
| 55. NAME OF ORDER | | 56. NAME OF SOCIETY | | 57. NAME OF CLUB | |
| 58. NAME OF GUILD | | 59. NAME OF ORDER | | 60. NAME OF SOCIETY | |
| 61. NAME OF CLUB | | 62. NAME OF GUILD | | 63. NAME OF ORDER | |
| 64. NAME OF SOCIETY | | 65. NAME OF CLUB | | 66. NAME OF GUILD | |
| 67. NAME OF ORDER | | 68. NAME OF SOCIETY | | 69. NAME OF CLUB | |
| 70. NAME OF GUILD | | 71. NAME OF ORDER | | 72. NAME OF SOCIETY | |
| 73. NAME OF CLUB | | 74. NAME OF GUILD | | 75. NAME OF ORDER | |
| 76. NAME OF SOCIETY | | 77. NAME OF CLUB | | 78. NAME OF GUILD | |
| 79. NAME OF ORDER | | 80. NAME OF SOCIETY | | 81. NAME OF CLUB | |
| 82. NAME OF GUILD | | 83. NAME OF ORDER | | 84. NAME OF SOCIETY | |
| 85. NAME OF CLUB | | 86. NAME OF GUILD | | 87. NAME OF ORDER | |
| 88. NAME OF SOCIETY | | 89. NAME OF CLUB | | 90. NAME OF GUILD | |
| 91. NAME OF ORDER | | 92. NAME OF SOCIETY | | 93. NAME OF CLUB | |
| 94. NAME OF GUILD | | 95. NAME OF ORDER | | 96. NAME OF SOCIETY | |
| 97. NAME OF CLUB | | 98. NAME OF GUILD | | 99. NAME OF ORDER | |
| 100. NAME OF SOCIETY | | 101. NAME OF CLUB | | 102. NAME OF GUILD | |
| 103. NAME OF ORDER | | 104. NAME OF SOCIETY | | 105. NAME OF CLUB | |
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| 109. NAME OF CLUB | | 110. NAME OF GUILD | | 111. NAME OF ORDER | |
| 112. NAME OF SOCIETY | | 113. NAME OF CLUB | | 114. NAME OF GUILD | |
| 115. NAME OF ORDER | | 116. NAME OF SOCIETY | | 117. NAME OF CLUB | |
| 118. NAME OF GUILD | | 119. NAME OF ORDER | | 120. NAME OF SOCIETY | |
| 121. NAME OF CLUB | | 122. NAME OF GUILD | | 123. NAME OF ORDER | |
| 124. NAME OF SOCIETY | | 125. NAME OF CLUB | | 126. NAME OF GUILD | |
| 127. NAME OF ORDER | | 128. NAME OF SOCIETY | | 129. NAME OF CLUB | |
| 130. NAME OF GUILD | | 131. NAME OF ORDER | | 132. NAME OF SOCIETY | |
| 133. NAME OF CLUB | | 134. NAME OF GUILD | | 135. NAME OF ORDER | |
| 136. NAME OF SOCIETY | | 137. NAME OF CLUB | | 138. NAME OF GUILD | |
| 139. NAME OF ORDER | | 140. NAME OF SOCIETY | | 141. NAME OF CLUB | |
| 142. NAME OF GUILD | | 143. NAME OF ORDER | | 144. NAME OF SOCIETY | |
| 145. NAME OF CLUB | | 146. NAME OF GUILD | | 147. NAME OF ORDER | |
| 148. NAME OF SOCIETY | | 149. NAME OF CLUB | | 150. NAME OF GUILD | |
| 151. NAME OF ORDER | | 152. NAME OF SOCIETY | | 153. NAME OF CLUB | |
| 154. NAME OF GUILD | | 155. NAME OF ORDER | | 156. NAME OF SOCIETY | |
| 157. NAME OF CLUB | | 158. NAME OF GUILD | | 159. NAME OF ORDER | |
| 160. NAME OF SOCIETY | | 161. NAME OF CLUB | | 162. NAME OF GUILD | |
| 163. NAME OF ORDER | | 164. NAME OF SOCIETY | | 165. NAME OF CLUB | |
| 166. NAME OF GUILD | | 167. NAME OF ORDER | | 168. NAME OF SOCIETY | |
| 169. NAME OF CLUB | | 170. NAME OF GUILD | | 171. NAME OF ORDER | |
| 172. NAME OF SOCIETY | | 173. NAME OF CLUB | | 174. NAME OF GUILD | |
| 175. NAME OF ORDER | | 176. NAME OF SOCIETY | | 177. NAME OF CLUB | |
| 178. NAME OF GUILD | | 179. NAME OF ORDER | | 180. NAME OF SOCIETY | |
| 181. NAME OF CLUB | | 182. NAME OF GUILD | | 183. NAME OF ORDER | |
| 184. NAME OF SOCIETY | | 185. NAME OF CLUB | | 186. NAME OF GUILD | |
| 187. NAME OF ORDER | | 188. NAME OF SOCIETY | | 189. NAME OF CLUB | |
| 190. NAME OF GUILD | | 191. NAME OF ORDER | | 192. NAME OF SOCIETY | |
| 193. NAME OF CLUB | | 194. NAME OF GUILD | | 195. NAME OF ORDER | |
| 196. NAME OF SOCIETY | | 197. NAME OF CLUB | | 198. NAME OF GUILD | |
| 199. NAME OF ORDER | | 200. NAME OF SOCIETY | | 201. NAME OF CLUB | |
| 202. NAME OF GUILD | | 203. NAME OF ORDER | | 204. NAME OF SOCIETY | |
| 205. NAME OF CLUB | | 206. NAME OF GUILD | | 207. NAME OF ORDER | |
| 208. NAME OF SOCIETY | | 209. NAME OF CLUB | | 210. NAME OF GUILD | |
| 211. NAME OF ORDER | | 212. NAME OF SOCIETY | | 213. NAME OF CLUB | |
| 214. NAME OF GUILD | | 215. NAME OF ORDER | | 216. NAME OF SOCIETY | |
| 217. NAME OF CLUB | | 218. NAME OF GUILD | | 219. NAME OF ORDER | |
| 220. NAME OF SOCIETY | | 221. NAME OF CLUB | | 222. NAME OF GUILD | |
| 223. NAME OF ORDER | | 224. NAME OF SOCIETY | | 225. NAME OF CLUB | |
| 226. NAME OF GUILD | | 227. NAME OF ORDER | | 228. NAME OF SOCIETY | |
| 229. NAME OF CLUB | | 230. NAME OF GUILD | | 231. NAME OF ORDER | |
| 232. NAME OF SOCIETY | | 233. NAME OF CLUB | | 234. NAME OF GUILD | |
| 235. NAME OF ORDER | | 236. NAME OF SOCIETY | | 237. NAME OF CLUB | |
| 238. NAME OF GUILD | | 239. NAME OF ORDER | | 240. NAME OF SOCIETY | |
| 241. NAME OF CLUB | | 242. NAME OF GUILD | | 243. NAME OF ORDER | |
| 244. NAME OF SOCIETY | | 245. NAME OF CLUB | | 246. NAME OF GUILD | |
| 247. NAME OF ORDER | | 248. NAME OF SOCIETY | | 249. NAME OF CLUB | |
| 250. NAME OF GUILD | | 251. NAME OF ORDER | | 252. NAME OF SOCIETY | |
| 253. NAME OF CLUB | | 254. NAME OF GUILD | | 255. NAME OF ORDER | |
| 256. NAME OF SOCIETY | | 257. NAME OF CLUB | | 258. NAME OF GUILD | |
| 259. NAME OF ORDER | | 260. NAME OF SOCIETY | | 261. NAME OF CLUB | |
| 262. NAME OF GUILD | | 263. NAME OF ORDER | | 264. NAME OF SOCIETY | |
| 265. NAME OF CLUB | | 266. NAME OF GUILD | | 267. NAME OF ORDER | |
| 268. NAME OF SOCIETY | | 269. NAME OF CLUB | | 270. NAME OF GUILD | |
| 271. NAME OF ORDER | | 272. NAME OF SOCIETY | | 273. NAME OF CLUB | |
| 274. NAME OF GUILD | | 275. NAME OF ORDER | | 276. NAME OF SOCIETY | |
| 277. NAME OF CLUB | | 278. NAME OF GUILD | | 279. NAME OF ORDER | |
| 280. NAME OF SOCIETY | | 281. NAME OF CLUB | | 282. NAME OF GUILD | |
| 283. NAME OF ORDER | | 284. NAME OF SOCIETY | | 285. NAME OF CLUB | |
| 286. NAME OF GUILD | | 287. NAME OF ORDER | | 288. NAME OF SOCIETY | |
| 289. NAME OF CLUB | | 290. NAME OF GUILD | | 291. NAME OF ORDER | |
| 292. NAME OF SOCIETY | | 293. NAME OF CLUB | | 294. NAME OF GUILD | |
| 295. NAME OF ORDER | | 296. NAME OF SOCIETY | | 297. NAME OF CLUB | |
| 298. NAME OF GUILD | | 299. NAME OF ORDER | | 300. NAME OF SOCIETY | |
| 301. NAME OF CLUB | | 302. NAME OF GUILD | | 303. NAME OF ORDER | |
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| 358. NAME OF GUILD | | 359. NAME OF ORDER | | 360. NAME OF SOCIETY | |
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| 472. NAME OF SOCIETY | | 473. NAME OF CLUB | | 474. NAME OF GUILD | |
| 475. NAME OF ORDER | | 476. NAME OF SOCIETY | | 477. NAME OF CLUB | |
| 478. NAME OF GUILD | | 479. NAME OF ORDER | | 480. NAME OF SOCIETY | |
| 481. NAME OF CLUB | | 482. NAME OF GUILD | | 483. NAME OF ORDER | |
| 484. NAME OF SOCIETY | | 485. NAME OF CLUB | | 486. NAME OF GUILD | |
| 487. NAME OF ORDER | | 488. NAME OF SOCIETY | | 489. NAME OF CLUB | |
| 490. NAME OF GUILD | | 491. NAME OF ORDER | | 492. NAME OF SOCIETY | |
| 493. NAME OF CLUB | | 494. NAME OF GUILD | | 495. NAME OF ORDER | |
| 496. NAME OF SOCIETY | | 497. NAME OF CLUB | | 498. NAME OF GUILD | |
| 499. NAME OF ORDER | | 499. NAME OF SOCIETY | | 499. NAME OF CLUB | |

BUREAU V. 1

OCT 28 1957

RECEIVED

CERTIFICATE OF DEATH

10896

Reg. Dist. No. 216

10905

| | | | | | |
|--|---|---|--|--|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
o. STATE Virginia b. COUNTY Fairfax | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | c. LENGTH OF STAY IN 1b
2 days | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | d. STREET ADDRESS
Springhill Road, P.O. Box 214 | | |
| 3. NAME OF DECEASED (Type or print)
First Charles Middle Stuart Last MacIntosh | | | 4. DATE OF DEATH
Month October Day 6 Year 1957 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 14, 1900 | 9. AGE (In years last birthday) 57 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
Newspaper Business | | 11. BIRTHPLACE (State or foreign country)
Scotland | |
| 13. FATHER'S NAME
Donald MacIntosh | | | 14. MOTHER'S MAIDEN NAME
Mary Morris | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Edematous pneumonia & fibrosis
150x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Esophagus metastatic to lung and liver
DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from October 4, 1957 , to October 6, 1957 , that I last saw the deceased alive on October 6, 1957 , and that death occurred at 5:20 P.M. from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE Theodore Robinson | | | M.D. The Clinical Center 10/7/57
National Institutes of Health
Bethesda 14, Maryland | | |
| PHYSICIAN'S NAME (Type) Theodore Robinson, M.D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) | (State) | |
| Buried | Oct. 9, 1957 | Nat. Army Park Cem. | Falls Church Va | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Cheng Chuan Fung | | | 24a. REC'D BY REGISTRAR
10-11-57 | 24b. REGISTRAR'S SIGNATURE
Bennie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
OCT 14 1957
BUREAU V. 3

OCT 14 1957

BUREAU V. 5.

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | c. LENGTH OF STAY IN 1b <u>15 years</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6304 Bells Mill Road</u> | d. STREET ADDRESS <u>6304 Bells Mill Rd</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Wayland Emmett Marders</u> | | 4. DATE OF DEATH <u>Oct 19 1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/29/1901</u> |
| 9. AGE (In years last birthday) <u>55 yrs.</u> | | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bkg Maintenance</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> | 11. BIRTH PLACE (State or foreign country) <u>Virginia</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Thomas Marders</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Carrie Pitts</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>Unknown</u> (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | 17. INFORMANT <u>Wife</u> Address <u>6304 Bells Mill Road</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u>
DUE TO <u>Carcinoma of lungs</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hours</u>
<u>1 year</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. _____ 19 _____ | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>December, 1953</u> , to <u>present</u> 19____, that I last saw the deceased alive on <u>Oct 19</u> , 19____, and that death occurred at <u>11 A.</u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Allen J. O'Neill</u> | | ADDRESS (Street, city or town, state) <u>8601 Old Georgetown Road Bethesda 14 Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u> | | DATE SIGNED _____ | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>10/23/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> | 22d. LOCATION (City, town, or county) (State) <u>Pt. Geo. Co., Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u> ADDRESS <u>1400 Chapin St. N.W. Wash. D.C.</u> | | 24a. REC'D BY REGISTRAR <u>OCT 22 1957</u> | 24b. REGISTRAR'S SIGNATURE <u>Jessie Thompson</u> |

1957 22 100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10898

Reg. Dist. No. 216

10907

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b
35 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Clinical Center, Bethesda 14, Maryland | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Topeka | | | |
| f. STREET ADDRESS
1268 Lakeside Drive | | | | g. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Fred Payne Martin | | | | 4. DATE OF DEATH Month Day Year
October 24, 1957 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
November 24, 1887 | |
| 9. AGE (In years last birthday)
69 yrs. | | IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tractor Dealer | | 11. BIRTHPLACE (State or foreign country)
Kansas | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
William Martin | | 14. MOTHER'S MAIDEN NAME
Temperance Ellis | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
Not available | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute renal failure & hepatic failure
DUE TO 199.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant carcinoma metastatic
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
2 days
6 mths | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from September 19, 1957 , to October 24, 1957 , that I last saw the deceased alive on October 24, 1957 , and that death occurred at 7:31 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Gurston Goldin</i> M.D. | | | | ADDRESS (Street, city or town, state)
The Clinical Center | | | |
| PHYSICIAN'S NAME (Type)
Gurston Goldin, M. D. | | | | DATE SIGNED
10/25/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Transit Bur | | 22b. DATE THEREOF
10/25/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Highland Cemetery | | 22d. LOCATION (City, town, or county) (State)
Ottawa City, Kansas | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | ADDRESS
Bethesda, Maryland | | 24a. REC'D BY REGISTRAR
DATE 10-26-57 | |
| 24b. REGISTRAR'S SIGNATURE
<i>Beanie M. Shroyer</i> | | | | | | | |

CERTIFICATE OF DEATH

Reg. No. 114

| | | | |
|--------------------------------------|--|-------------------------------------|--|
| NAME OF DECEASED
[Illegible] | | DATE OF BIRTH
[Illegible] | |
| SEX
[Illegible] | | RACE
[Illegible] | |
| EDUCATION
[Illegible] | | OCCUPATION
[Illegible] | |
| MARITAL STATUS
[Illegible] | | PLACE OF BIRTH
[Illegible] | |
| DATE OF DEATH
[Illegible] | | TIME OF DEATH
[Illegible] | |
| CAUSE OF DEATH
[Illegible] | | MANNER OF DEATH
[Illegible] | |
| PLACE OF DEATH
[Illegible] | | CITY OF DEATH
[Illegible] | |
| COUNTY OF DEATH
[Illegible] | | STATE OF DEATH
[Illegible] | |
| SIGNATURE OF DECEASED
[Illegible] | | SIGNATURE OF WITNESS
[Illegible] | |
| DATE OF SIGNATURE
[Illegible] | | DATE OF SIGNATURE
[Illegible] | |
| PLACE OF SIGNATURE
[Illegible] | | PLACE OF SIGNATURE
[Illegible] | |
| CITY OF SIGNATURE
[Illegible] | | CITY OF SIGNATURE
[Illegible] | |
| COUNTY OF SIGNATURE
[Illegible] | | COUNTY OF SIGNATURE
[Illegible] | |
| STATE OF SIGNATURE
[Illegible] | | STATE OF SIGNATURE
[Illegible] | |
| DATE OF DEATH
[Illegible] | | TIME OF DEATH
[Illegible] | |
| CAUSE OF DEATH
[Illegible] | | MANNER OF DEATH
[Illegible] | |
| PLACE OF DEATH
[Illegible] | | CITY OF DEATH
[Illegible] | |
| COUNTY OF DEATH
[Illegible] | | STATE OF DEATH
[Illegible] | |

BUREAU V. 2

OCT 28 1957

RECEIVED

10908

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|----------------------------------|---|---------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
x2 Bethesda | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
9001 Georgetown Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Joanna Middle McDonnell Last McDonnell | | | | 4. DATE OF DEATH
Month October Day 23 Year 19 57 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-28-1876 | | 9. AGE (In years last birthday)
80 yrs. | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Catholic Nun | | 10b. KIND OF BUSINESS OR INDUSTRY
Religious | | 11. BIRTHPLACE (State or foreign country)
Illinois | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John McDonnell | | | | 14. MOTHER'S MAIDEN NAME
Winifred Murphy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Convent Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - Coronary Heart Disease
(c) 10 years | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 minute |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January , 19 50 , to October 23 , 19 57 , that I last saw the deceased alive on October 22 , 19 57 , and that death occurred at 3 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Michael J. McInerney M.D. | | | | ADDRESS (Street, city or town, state) 1150 Conn. Ave. N.W. - Washington, D.C. | | | |
| PHYSICIAN'S NAME (Type) Michael J. McInerney | | | | DATE SIGNED 10-23-57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/25/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Convent Cemetery | | 22d. LOCATION (City, town, or county) (State)
Bethesda, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Francis J. Collins | | | | ADDRESS
3824-14th NW Wash. D.C. | | 24a. REC'D BY REGISTRAR
DATE 10-29-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | | | |

CERTIFICATE OF DEATH

| | | | | | |
|--------------------------------------|--|---------------------------------------|--|---------------------------------------|--|
| NAME OF DECEASED
[Illegible] | | SEX
[Illegible] | | AGE
[Illegible] | |
| PLACE OF BIRTH
[Illegible] | | DATE OF BIRTH
[Illegible] | | PLACE OF DEATH
[Illegible] | |
| OCCUPATION
[Illegible] | | CAUSE OF DEATH
[Illegible] | | MANNER OF DEATH
[Illegible] | |
| DATE OF DEATH
[Illegible] | | TIME OF DEATH
[Illegible] | | PLACE OF INTERMENT
[Illegible] | |
| SIGNATURE OF DECEASED
[Illegible] | | SIGNATURE OF WITNESS
[Illegible] | | SIGNATURE OF PHYSICIAN
[Illegible] | |
| SIGNATURE OF CLERK
[Illegible] | | SIGNATURE OF REGISTRAR
[Illegible] | | SIGNATURE OF JUDGE
[Illegible] | |

BUREAU V. S.

OCT 31 1957

RECEIVED

10900
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 8 Film G222 11-7-57 et
CERTIFICATE OF DEATH

Reg. Dist. No.

10900 217

| | | | | | | | |
|---|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney
c. LENGTH OF STAY IN 1b
17 days
d. NAME OF HOSPITAL (If not in hospital, give street address)
Montgomery Co. General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
111 7 Montpelier Rd. Manor Club, Rockville, Md
d. STREET ADDRESS
Rockville, Maryland
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Thomas Joseph Mc Grath | | | | 4. DATE OF DEATH
October 10 19 57 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-2-87
October 2, 1886 | 9. AGE (In years last birthday)
71 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Lawyer | | 10b. KIND OF BUSINESS OR INDUSTRY
Self-Employed | | 11. BIRTHPLACE (State or foreign country)
Minn. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Mc Grath | | | | 14. MOTHER'S MAIDEN NAME
Helen Tracy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
270-09-1315 | | 17. INFORMANT
Hospital Record
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Congestive Heart Failure DUE TO
(c) Coronary Heart Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH
17 days
17 days
3 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 9-23-57 , 19____, to 10-10-57 , 19____, that I last saw the deceased alive on 10-10-57 , 19____, and that death occurred at 8:27 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Olney, Md.
DATE SIGNED 10-10-57
ACTUAL SIGNATURE Richard A. Yates M.D.
PHYSICIAN'S NAME (Type) R. A. Yates, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10/14/57 | 22c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN CEMETERY | | 22d. LOCATION (City, town, or county) (State)
MONTGOMERY COUNTY, MD. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Warner E. Humphrey
ADDRESS
SILVER SPRING, MD. | | | 24a. REC'D BY REGISTRAR
10-14-1957
DATE | | 24b. REGISTRAR'S SIGNATURE
Gertude Lawley | | |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED
John McNamee | | 2. SEX
Male | | 3. AGE
45 | |
| 4. OCCUPATION
Laborer | | 5. MARITAL STATUS
Married | | 6. PLACE OF BIRTH
Maryland | |
| 7. DATE OF DEATH
10-10-57 | | 8. TIME OF DEATH
10:00 AM | | 9. PLACE OF DEATH
Home | |
| 10. CAUSE OF DEATH
Heart Disease | | 11. MANNER OF DEATH
Natural | | 12. SIGNATURE OF PHYSICIAN
[Signature] | |
| 13. SIGNATURE OF REGISTRAR
[Signature] | | 14. SIGNATURE OF WITNESSES
[Signature] | | 15. SIGNATURE OF DECEASED
[Signature] | |

BUREAU V. R.

OCT 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10798

CERTIFICATE OF DEATH

10901

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> | | | |
| c. LENGTH OF STAY IN 1b <u>15 min.</u> | | | | d. STREET ADDRESS <u>729 21st Ave.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Jan. & Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>MABEL</u> First <u>MARIE</u> Middle <u>McKAY</u> Last | | | | 4. DATE OF DEATH <u>OCT. 24</u> Month <u>24</u> Day <u>19</u> Year <u>57</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8/14/87</u> | |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u> | |
| 13. FATHER'S NAME <u>Henry Schulze</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Dean</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Son, Mr. Norman C. McKay, 2700 Conn. Ave. NW</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary edema - Acute</u>
<u>443X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vasc</u>
<u>Heart Disease</u>
(c) <u>SEVERAL YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Washington</u>
ONSET AND DEATH <u>1-2 HRS.</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Jan. 15, 1957</u> to <u>Oct. 24, 1957</u> that I last saw the deceased alive on <u>Oct 15, 1957</u> , and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Lynwood Heiges</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>6940 PINEY BRANCH RD., NW, WASH. D.C.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>LYNWOOD HEIGES, M.D., F.A.C.A.</u> | | | | DATE SIGNED <u>10/24/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>10/28/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. MEM. CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u> | | | | ADDRESS <u>SILVER SPRING, MD.</u> | | 24a. REC'D BY REGISTRAR <u>W. H. DODD</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE | | DATE <u>OCT 28 1957</u> | |

CERTIFICATE OF DEATH

MABEL MARIE McVAY

X

W

F

OUR LINE

HOT WATER

Henry Gehlge

NAME

NO

Correct certified by me

Immunized

BUREAU V. S.

OCT 28 1957

RECEIVED

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10902/6

10910

| | | | |
|--|---------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b <i>28 hrs</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i> | | d. STREET ADDRESS <i>9311 New Hampshire Ave</i> | |
| 3. NAME OF DECEASED (Type or print) <i>John ELIAS MEYER</i> | | 4. DATE OF DEATH <i>10 18 19 57</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9-14-83</i> |
| 9. AGE (In years last birthday) <i>74</i> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>S. Carolina</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>John Edward Meyer</i> | | 14. MOTHER'S MAIDEN NAME <i>Susan Hudson</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>140</i> | |
| 17. INFORMANT <i>Mary Meyer</i> | | Address <i>9311 N. Ham Ave</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>congestive Heart Failure</i>
<i>420.1</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Myocardial Insufficiency</i>
DUE TO
(c) <i>Coronary arteriosclerosis, severe</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>24 hours</i>
<i>4 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>Carcinoma of Stomach with serosal implants</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. y. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Jan 18, 1954</i> , to <i>18 Oct 1957</i> , that I last saw the deceased alive on <i>18 Oct 1957</i> , and that death occurred at <i>7:25 P.M.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>W S Murphy</i> | | M.D. <i>615 W. Montgomery Road, Rockville, Md 20855</i> | |
| PHYSICIAN'S NAME (Type) <i>W S Murphy</i> | | DATE SIGNED <i>10-19-57</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i> | | 22b. DATE THEREOF <i>10-19-57</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>J.W. Lee Crematory</i> | | 22d. LOCATION (City, town, or county) (State) <i>300-4th St. NE, Wash DC</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John Lee & Sons</i> | | ADDRESS <i>Washington</i> | |
| 24a. REC'D BY REGISTRAR <i>Beaumont Thompson</i> | | 24b. REGISTRAR'S SIGNATURE <i>Beaumont Thompson</i> | |
| DATE <i>10-22-1957</i> | | | |

Yr. 1957, Feb 11

2842

2004/5/25

John Elias

92x3m

88-41-P

23

847029

John Edward Miller

May 1987

24 Jan

755

BUCHANAN, K. S.

1260

2000

529-91-1-10

— 100 —

OCT 22 1957

RECEIVED

10911 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|---|---|--|---|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Grosvenor Lane & Old Georgetown Rd. | | | | d. STREET ADDRESS
6415 Tisdale Terrace | | | |
| 3. NAME OF DECEASED (Type or print)
First Keith Middle High Last MILLER | | | | 4. DATE OF DEATH
Month October Day 30 Year 19 57 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 15, 1923 | | 9. AGE (In years last birthday)
34 yrs. | IF UNDER 1 YEAR
Months 9 Days 15 | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Economist | | 10b. KIND OF BUSINESS OR INDUSTRY
Government | | 11. BIRTHPLACE (State or foreign country)
New Mexico | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Fred High Miller | | | | 14. MOTHER'S MAIDEN NAME
Louise Wilkinson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
WW 11 | | 17. INFORMANT Hope W. Miller Address Nada's Miller Item # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage and laceration dots
DUE TO (b) Bullet wound through skull
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Self-inflicted bullet wound thru skull | | | | | |
| 20c. TIME OF INJURY
? Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Bethesda | | (County)
Montg. | (State)
Maryland |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | October 30, 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Bur. - Trans. | 22b. DATE THEREOF
11/1/57 | 22c. NAME OF CEMETERY OR CREMATORY
Charles Evans | | 22d. LOCATION (City, town, or county) (State)
Reading, Pennsylvania | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey - Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 11-1-57 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

NOV 4 1957

BUREAU A. R.

Self-inflicted bullet wound (near skull)

Bullet wound through skull

Cerebral hemorrhage and laceration of brain

Yes

WW II

James E. Miller

Lucille Miller

Red High Miller

Government

Economist

New Mexico

White

Married Jan. 13, 1953

High

Keith

Greenville Lane & Old Georgetown Rd.

8401 Virginia Avenue

Bedroom

Bedroom

Monogram by

Monogram

Monogram

Monogram

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G221 10-18-57 et.

CERTIFICATE OF DEATH

Reg. Dist. No.

10904

10912

| | | | | | |
|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellevue Spring</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47x-3</u> ✓ | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2210 - RICHLAND PL. SILSPEED</u> | | | d. STREET ADDRESS <u>7621 - 9th N.W.</u> | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>ANNIE FISHKIN MIRIN</u> | | | 4. DATE OF DEATH Month Day Year
<u>OCT. 12 1957</u> | | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>SEPT. 24 1879</u> | 9. AGE (In years lost birthday)
<u>78</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country)
<u>RUSSIA</u> | | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | |
| 13. FATHER'S NAME
<u>Israel Fishkin</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT
<u>SIMON MIRIN</u> | | | Address <u>2210 RICHLAND PL. S.E. SFG. MD.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
<u>10 MIN</u>
<u>5 YRS</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from <u>NOV 1, 1954</u> to <u>OCT 12, 1957</u> , that I last saw the deceased alive on <u>OCT 10, 1957</u> , and that death occurred at <u>3:50 A.M.</u> from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>Arthur H Lewis</u> | | M.D. <u>1714 R.I. Ave NW</u> | | ADDRESS (Street, city or town, state) <u>Washington DC</u> | |
| PHYSICIAN'S NAME (Type) <u>ARTHUR H. LEWIS</u> | | DATE SIGNED <u>10-12-57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>OCT. 13, 1957</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>MITLEBANDON CEM. FRIENDSHIP LODGE</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Hyattsville, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Bernard Danzansky & Sons-3501 14th St., N.W. (10)</u> | | ADDRESS | | 24a. REC'D BY REGISTRAR
<u>OCT 15 1957</u> | 24b. REGISTRAR'S SIGNATURE
<u>Frances Pitero</u> |

10913

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1957 31 OCT

RECEIVED

BUREAU V.

10914

CERTIFICATE OF DEATH

Reg. Dist. No. 213

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural-Potomac | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural-Potomac x2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
RFD Rockville | | | | d. STREET ADDRESS
RFD Rockville | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First DAVID Middle GOUGH Last MORGAN | | | | 4. DATE OF DEATH
Month Oct. Day 30 Year 1957 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 11, 1929 | |
| 9. AGE (In years last birthday)
28 yrs. | | IF UNDER 1 YEAR
Months 5 Days 19 | | IF UNDER 24 HRS.
Hours 19 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Social Scientist | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Fed. Gov't. | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Jo. V. Morgan | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Crenshaw | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Father
Address
Jo. V. Morgan-5426 Moorland Lane, Beth. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 300ct 57 | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 30 Oct 57 to 30 Oct 57 , that I last saw the deceased alive on 30 Oct 57 , 19 57 , and that death occurred at 12:04 M, from the causes and on the date stated above.
ADDRESS (Street, City or town, state) Rockville, Maryland
DATE SIGNED 30 Oct 57
ACTUAL SIGNATURE W. S. Murphy M.D. Reynolds
PHYSICIAN'S NAME (Type) W. S. Murphy Rockville, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/1/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Rockville Union Cem. | | 22d. LOCATION (City, town, or county) (State)
Rockville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | 24a. REC'D BY REGISTRAR
NOV 1 1957 | | 24b. REGISTRAR'S SIGNATURE
L. Kragtorp | |

Deputy Medical Examiner notified and approved (Frank J. Brosehart)

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10915

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 FilmG221 10-11-57 et.

10997

Reg. Dist. No. 277

| | | | |
|---|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u> | | c. LENGTH OF STAY IN 1b <u>14 yrs</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Clarksburg</u> | |
| | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Morris</u> Last | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>5</u> Year <u>1957</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-19-1873</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>va</u> | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James Morris</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Hamm</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Catherine Hamm</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u>
<u>443X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u>
(a), stating the underlying cause lost. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 hrs</u>
<u>3 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-7-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Guingue</u> | | 22d. LOCATION (City, town, or county) (State) <u>Guingue Va</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hood & Sons Funeral Home</u> | | ADDRESS <u>Guingue Va</u> | |
| 24a. REC'D BY REGISTRAR <u>Oct 8, 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Della N. Burdette</u> | |

BUREAU V. 11

9 OCT 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10908
Reg. Dist. No. 223

10799

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Washington, D.C.</u> b. COUNTY <u>47X-3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u> | | d. STREET ADDRESS <u>2110 S St. N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>NMN</u> Last <u>Mott</u> | | 4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1957</u> | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-3-180</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>D. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Armistead Peter</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Custis Kennan</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 hrs</u>
<u>4 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct 2</u> , 19 <u>57</u> , to <u>Oct 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 5</u> , 19 <u>57</u> , and that death occurred at <u>1:15</u> A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D. | | DATE SIGNED <u>Oct 6 1957</u> | |
| PHYSICIAN'S NAME (Type) <u>James M. Whitlock, 7701 Carroll Ave. Takoma Park, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 22b. DATE THEREOF <u>10/9/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Birch Funeral Home 3034 M St. N.W.</u> | | 24a. REC'D BY REGISTRAR DATE <u>10/10/57</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>J. M. Rody</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

10916

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE New Jersey
b. COUNTY Collingswood 67X-3 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/>
Collingswood | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS
212 Collings Avenue | | | |
| 3. NAME OF DECEASED (Type or print)
First Robert Middle Kevin Last Murphy | | | | 4. DATE OF DEATH
Month October Day 17 Year 1957 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
September 26, 1955 | |
| 9. AGE (In years last birthday)
2 yrs. | | IF UNDER 1 YEAR
Months 2 Days 2 Hours 2 Min. | | IF UNDER 24 HRS.
Months 2 Days 2 Hours 2 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Child | | | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
New Jersey | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Edward L. Murphy | | | | 14. MOTHER'S MAIDEN NAME
Shirley Lehman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ? Septicemia
204.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphatic Leukemia
DUE TO (c) 7 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fat necrosis of unknown etiology
INTERVAL BETWEEN ONSET AND DEATH 12 hrs. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from August 6, 1957 , to October 17, 1957 , that I last saw the deceased alive on October 17, 1957 , and that death occurred at 10:00 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Dane R. Boggs M.D. | | | | ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/17/57 | | | |
| PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D. | | | | National Institutes of Health
Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 22b. DATE THEREOF 10-18-57 | | 22c. NAME OF CEMETERY OR CREMATORY | |
| 22d. LOCATION (City, town, or county) (State) | | | | Collingswood N.J. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
See Funeral Home - Wood | | | | ADDRESS | | 24a. REC'D BY REGISTRAR
Oct 21 1957 | |
| 24b. REGISTRAR'S SIGNATURE
Kessie Thompson | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|-------------------------------------|--|
| DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
STATE OF NEW YORK | | DATE OF DEATH
OCT 21 1957 | |
| NAME OF DECEASED
[Illegible] | | SEX
[Illegible] | |
| AGE
[Illegible] | | RACE
[Illegible] | |
| PLACE OF BIRTH
[Illegible] | | PLACE OF DEATH
[Illegible] | |
| DATE OF BIRTH
[Illegible] | | TIME OF DEATH
[Illegible] | |
| CAUSE OF DEATH
[Illegible] | | MANNER OF DEATH
[Illegible] | |
| SIGNATURE OF DECEASED
[Illegible] | | SIGNATURE OF WITNESS
[Illegible] | |
| SIGNATURE OF PHYSICIAN
[Illegible] | | SIGNATURE OF CORONER
[Illegible] | |
| SIGNATURE OF JUDGE
[Illegible] | | SIGNATURE OF CLERK
[Illegible] | |

BUREAU V. R.

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10910
218

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Gaithersburg. | | c. LENGTH OF STAY IN life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. F. D. #2 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle NELSON Last MURRAY | | 4. DATE OF DEATH Month Oct. Day 6, Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 10, 1870 |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edward Nelson | | 14. MOTHER'S MAIDEN NAME Sarah Russell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Rev. Robert Murray | | Address Germantown, Md. Route #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma
151X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of stomach
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anaemia | | INTERVAL BETWEEN ONSET AND DEATH
5 months
1 year | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 17 Nov., 1949 , to 6 Oct., 1957 , that I last saw the deceased alive on 6 Oct., 1957 , and that death occurred at 4 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John J. Lawrence M.D. | | ADDRESS (Street, city or town, state) P.O. Bayard, Md DATE SIGNED Wed 10/9/57 | |
| PHYSICIAN'S NAME (Type) _____ | | _____ | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/11/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Seneca | | 22d. LOCATION (City, town, or county) (State) Seneca, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR 6 OCT 14 1957 DATE 14 1957 24b. REGISTRAR'S SIGNATURE Robert Snowden | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|----------------------|--|-----------------------|--|--------------------------|--|--------------------|--|------------------------|--|--------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. HARRIS | | M | | 45 | | JAN 10 1912 | | BALTIMORE | | MARYLAND | | MARYLAND | | UNITED STATES | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | RACE | | COLOR | | HAIR | | EYES | |
| LABORER | | HIGH SCHOOL | | MARRIED | | METHODIST | | WHITE | | WHITE | | BROWN | | BLUE | |
| CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | |
| HEART DISEASE | | SUICIDE | | 3 WEEKS | | OCT 12 1957 | | BALTIMORE | | MARYLAND | | MARYLAND | | UNITED STATES | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF CLERK | | SIGNATURE OF REGISTRAR | | SIGNATURE OF JUDGE | | SIGNATURE OF SHERIFF | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |
| DATE | | TIME | | PLACE | | CITY | | STATE | | COUNTRY | | REMARKS | | REMARKS | |
| OCT 14 1957 | | 10:00 AM | | BALTIMORE | | MARYLAND | | UNITED STATES | | REMARKS | | REMARKS | | REMARKS | |

BUREAU V. S.

OCT 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10918

CERTIFICATE OF DEATH

10911

Reg. Dist. No.

217

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | | | c. LENGTH OF STAY IN 1b
6 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Montgomery Co. General Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Gary Lynn Neal | | | | 4. DATE OF DEATH
Month Day Year
October 20 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/14/57 | |
| 9. AGE (In years last birthday)
yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | 10. AGE (In years last birthday)
yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Newborn | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Jeffery Neal, Jr. | | | | 14. MOTHER'S MAIDEN NAME
Sarah Olivia Dent | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mother (14) | | Address
Boyds, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Interstitial pneumonia
763.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Prematurity (approximately 7 mos. gestation period) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
48 hrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/14/57 , 19____, to 10/20/57 , 19____, that I last saw the deceased alive on 10/20/57 , 19____, and that death occurred at 9:30A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____
ACTUAL SIGNATURE G. F. Meadors M.D. Damascus 10/21/57
PHYSICIAN'S NAME (Type) G. F. Meadors M.D. Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/22/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Emory Grove | | 22d. LOCATION (City, town, or county) (State)
Emory Grove, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert L. Snowden | | | | ADDRESS
Rockville, Md. | | 24a. REC'D BY REGISTRAR
DATE 25 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
G. T. L. L. L. | | | |

2073276XV2

BUREAU V. S.

OCT 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10912

10919

CERTIFICATE OF DEATH

Reg. Dist. No. 217

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | | | c. LENGTH OF STAY IN 1b
3 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Montgomery Co. General Hospital | | | | d. STREET ADDRESS
Rt. #3 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Lillie Middle Mae Last Nichols | | | | 4. DATE OF DEATH
Month October Day 12 Year 1957 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/17/22 | |
| 9. AGE (In years last birthday)
35 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 13. FATHER'S NAME
Jesse Gilmore | | | | 14. MOTHER'S MAIDEN NAME
Lula Zeigler | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Hospital Record
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Failure
580X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) Liver Atrophy (Cause Undetermined)
DUE TO (b)
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from August, 1957 , to Oct 12, 1957 , that I last saw the deceased alive on Oct 12, 1957 , and that death occurred at 9:05 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Luciano J. Leal | | | | ADDRESS (Street, city or town, state) Gaithersburg Md.
DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) L. I. Leal, M. D. | | | | Gaithersburg, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct 14/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Union Cemetery | | 22d. LOCATION (City, town or county) (State)
Leesburg Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ray W. Barber | | | | ADDRESS
Daytonville | | 24a. REC'D BY REGISTRAR
DATE 10-16-57 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE
Gertrude B. Lawler | |

OCT 18 1957

BUREAU V. 5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

10920

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10913

Reg. Dist. No. 216

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda X 2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
6016 Massachusetts Avenue | | d. STREET ADDRESS
6016 Massachusetts Avenue | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Maude Middle Estelle Last NITZEL | | 4. DATE OF DEATH
Month October Day 9 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 12, 1880 |
| 9. AGE (In years last birthday)
76 yrs. | | IF UNDER 1 YEAR
Months 11 Days 25 | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired School teacher | | 10b. KIND OF BUSINESS OR INDUSTRY
Teaching | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Charles Andrew Nitzel | | 14. MOTHER'S MAIDEN NAME
Virginia Caton | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Charles O'Brien-nephew-Same Item #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
774 x
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Hanging
(a), stating the underlying cause lost. DUE TO (c) Sudden | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Hung self by neck with rope at home | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Hung self by neck with rope at home | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-12-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State)
Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Francis J. Collins | | ADDRESS 3821 14th. N.W. | |
| DATE 10-11-57 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|--|--|
| Name of Deceased
Charles Andrew | | Sex
Male | | Age
31 | |
| Date of Death
Oct. 2, 1930 | | Place of Death
Home | | Cause of Death
Heart | |
| Residence
101 Massachusetts Avenue | | City
Boston | | County
Suffolk | |
| Occupation
Teacher | | Education
High School | | Marital Status
Single | |
| Signature of Physician
Charles Andrew | | Signature of Medical Examiner
Frank B. Brown | | Signature of Coroner
John J. Connelley | |

Found dead by neck with rope at home

BUREAU V. B.

OCT 14 1937

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10914

10921

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | | | |
|---|----------------------------------|--|---|--|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>56 SILVER SPRING</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>1607 DUBLIN DRIVE.</u> | | | | d. STREET ADDRESS
<u>1607 DUBLIN DRIVE.</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>CATHERINE DRUGILLA NUANES</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>OCTOBER 27 1957</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>APRIL 4, 1906</u> | 9. AGE (In years last birthday)
<u>51</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>WASHINGTON, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> |
| 13. FATHER'S NAME
<u>GEORGE W. CHATHAM</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>KIRBY SARAH.</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>NO</u>
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>MRA JUAN NUANES</u> | | Address
<u>SAME.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>DIABETES MELLITUS WITH ACIDOSIS</u>
<u>260X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO
(c) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 WEEKS.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>HEMIPLEGIA LEFT DUE TO BRAIN TRAUMA 4 YRS.</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>SEPT. 9, 1955</u> , to <u>OCT. 27, 1957</u> , that I last saw the deceased alive on <u>OCT. 27, 1957</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>James Roberts</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>8907 GEORGIA AVE. SILVER SPRING MD 10/27/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>10/31/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>ARLINGTON NATIONAL</u> | | 22d. LOCATION (City, town, or county) (State)
<u>FT. MYER, VA.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. W. Chamber Co. 5801 Cleveland Ave.</u> | | | | 24. REC'D BY REGISTRAR
<u>10/31/1957</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Frances Patter</u> | |

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

10922

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. COUNTY Montgomery MARYLAND | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4416 Stanford Street | | | | d. STREET ADDRESS
4416 Stanford Street | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) MARY First ANN Middle O'BRIEN Last | | | | 4. DATE OF DEATH Oct. 19, Month 1957 Day Year | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1/6/70 | |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR
Months 9 Days 13 | | IF UNDER 24 HRS.
Hours 13 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Ireland | |
| 12. CITIZEN OF WHAT COUNTRY?
US | | | | | | | |
| 13. FATHER'S NAME
Daniel Houregan | | | | 14. MOTHER'S MAIDEN NAME
Ellen Dwan | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
William C. O'Brien-Item # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular/accident
332x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral thrombosis
DUE TO (c) Arteriosclerosis, generalized | | | | INTERVAL BETWEEN ONSET AND DEATH
4 days
4 days
years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Oct. 17, 1957 to Oct. 19, 1957 , that I last saw the deceased alive on October 19, 1957 , and that death occurred at 3:35 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 4630 Montgomery Ave. DATE SIGNED 10/19/57
ACTUAL SIGNATURE Robert N. Coale M.D. Bethesda, Md.
PHYSICIAN'S NAME (Type) ROBERT N. COALE | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/22/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | | 22d. LOCATION (City, town, or county) (State)
Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 10-21-57 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cheryl Lynn

077451

125199

1999:11, 16

[illegible]

2007

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Robert F. Montgomery-Delmonde, MD

19910314

70122101 18.001

04501240

OCT 23 1957

BUREAU V. S.

RECEIVED

10923

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE (District of Columbia) b. COUNTY 1 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN TB 11 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington (27) 1682-2 | | | |
| 3. NAME OF DECEASED (Type or print) First Matthew Middle Francis Last O'BRIEN | | | | 4. DATE OF DEATH Month October Day 18 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 17 July 1893 | |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months 6 Days 18 Hours 57 Min. | | IF UNDER 24 HRS. Hours 57 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired) | | 11. BIRTHPLACE (State or foreign country) Rhode Island | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Joseph O'BRIEN | | | | 14. MOTHER'S MAIDEN NAME Ellen CONNLEY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1-30-22 to 1-30-46 (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address (Wife) Mrs. Mildred A. D'BRIEN (Same As #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 600.0 DUE TO Wremia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral Chronic pyelonephritis
lying cause last. (c) 2-3 mos
2-3 years at least | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 7 Oct. , 19 57 , to 18 Oct. , 19 57 , that I last saw the deceased alive on 18 Oct. , 19 57 , and that death occurred at 12:10 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 10-18-57 | | | | | | | |
| ACTUAL SIGNATURE Byron D. Casteel M.D. | | | | PHYSICIAN'S NAME (Type) Byron D. Casteel, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-22-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.D. Chambers ADDRESS 517 11th St, S.E. Washington, D.C. | | | | 24a. REC'D BY REGISTRAR Mary E. Farrelly 24b. REGISTRAR'S SIGNATURE DATE 10-18-57 | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. 1

OCT 21 1957

RECEIVED

10924

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X2 Bethesda | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
7923 Chelton | | | | d. STREET ADDRESS
1 7923 Chelton | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
HARRY WHITNEY OSGOOD | | | | 4. DATE OF DEATH
Month Day Year
Oct. 26, 1957 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 24, 1883 | |
| 9. AGE (In years last birthday)
74 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
5 2 | | IF UNDER 24 HRS.
2 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired-Electrical Engineer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Engineer | | 11. BIRTHPLACE (State or foreign country)
Massachusetts | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | | | | | |
| 13. FATHER'S NAME
Joseph Osgood | | | | 14. MOTHER'S MAIDEN NAME
Josephine Whitney | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
? | | 17. INFORMANT Wife
Mrs. Elizabeth N. Osgood Address Item #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion.
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis -
DUE TO (c) Arteriosclerosis -
INTERVAL BETWEEN ONSET AND DEATH
10 min.
4 yr.
10 yr. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 1952 to 26 Oct , 1957, that I last saw the deceased alive on 24 Oct , 1957, and that death occurred at 7:30 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 7936 Old Georgetown Rd. DATE SIGNED 26 Oct 57 | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | | M.D. 7936 Old Georgetown Rd. | | | |
| PHYSICIAN'S NAME (Type) JOHN G. BALL | | | | Bethesda, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 22b. DATE THEREOF
10-29-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) (State)
Prince George Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
ROBERT A. PUMPHREY ADDRESS Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 10-29-57 | | 24b. REGISTRAR'S SIGNATURE
Bernice M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-----------------------|--|------------------------|--|----------------------|--|----------------------|--|------------------------|--|--------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1922 | | MOBILE, ALABAMA | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | | PERIOD OF ILLNESS | |
| APRIL 4, 1968 | | MEMPHIS, TENNESSEE | | SHOOTING | | HOMICIDE | | GUNSHOT WOUNDS | | 24 HOURS | |
| TIME OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | MARITAL STATUS | | SINGLE | |
| 10:00 AM | | CONTRACTOR | | HIGH SCHOOL | | METHODIST | | MARRIED | | WIFE: KATHLEEN SUSAN RAY | |
| SIGNATURE OF DECEASED | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF WITNESS | | SIGNATURE OF REGISTRAR | | SIGNATURE OF CLERK | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU VI

CT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10918
218

Reg. Dist. No.

10925

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gaithersburg | | | c. LENGTH OF STAY IN 1b
X2 Gaithersburg | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
1 Gaithersburg | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Metropolitan Grove | | | | d. STREET ADDRESS
Metropolitan Grove | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Preston Harrison Pannell | | | | 4. DATE OF DEATH
Month Day Year
Oct. 20. 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4/11/88 | |
| 9. AGE (In years last birthday)
69 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
laborer | |
| 11. BIRTHPLACE (State or foreign country)
Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Kate Pannell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Mrs Denie Pannell 2801 Sherman Ave., N. W. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) in bed
(c) Found dead
DUE TO
(a) stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Found dead
in bed |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Brubaker M.D.
EXAMINER'S NAME (Type) F | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REBURY (Specify) | | 22b. DATE THEREOF
10/23/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Lincoln Memorial, | | 22d. LOCATION (City, town, or county) (State)
Suitland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert L. Snodden | | | | ADDRESS
Rockville, Md. | | 24a. REC'D BY REGISTRAR
OCT 25 1957 | |
| 24b. REGISTRAR'S SIGNATURE
Wanda G. Cook | | | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or reburial.

STANDARD STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| NAME OF DECEASED
JAMES EARL RAY | | SEX
Male | |
| AGE
35 | | RACE
White | |
| DATE OF DEATH
4/4/68 | | TIME OF DEATH
10:00 AM | |
| PLACE OF DEATH
Room 1001, Federal Bureau of Investigation, Washington, D.C. | | CAUSE OF DEATH
Gunshot wound | |
| MANNER OF DEATH
Homicide | | MEDICAL HISTORY
None | |
| SIGNATURE OF EXAMINER
J. Edgar Hoover | | SIGNATURE OF DECEASED
James Earl Ray | |
| TITLE OF EXAMINER
Director | | TITLE OF DECEASED
Subject | |
| ADDRESS OF EXAMINER
400 Maryland Avenue, N.W., Washington, D.C. | | ADDRESS OF DECEASED
Room 1001, Federal Bureau of Investigation, Washington, D.C. | |
| SIGNATURE OF WITNESS
J. Edgar Hoover | | SIGNATURE OF WITNESS
James Earl Ray | |
| TITLE OF WITNESS
Director | | TITLE OF WITNESS
Subject | |
| ADDRESS OF WITNESS
400 Maryland Avenue, N.W., Washington, D.C. | | ADDRESS OF WITNESS
Room 1001, Federal Bureau of Investigation, Washington, D.C. | |

RECEIVED
 OCT 25 1967
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10926

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10919

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Washington, D.C. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington, D.C. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
6401 Brookside Drive | | | | d. STREET ADDRESS
810-5th. Street, N. W. | | | |
| 3. NAME OF DECEASED (Type or print)
JAMES L. PARKER | | | | 4. DATE OF DEATH
Oct. 9, 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec. 6, 1900 | |
| 9. AGE (In years last birthday)
56 | | IF UNDER 1 YEAR
10 Months 3 Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Landscape Gardner | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Self Emp. | | 11. BIRTHPLACE (State or foreign country)
Maine | |
| 12. CITIZEN OF WHAT COUNTRY?
US | | | | | | | |
| 13. FATHER'S NAME
? Parker | | | | 14. MOTHER'S MAIDEN NAME
Mary Anderson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Perry W. Wright-94 Forest Ave. Orno, Maine | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (b) 420.1
(a), stating the underlying cause last, (c) DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
sudden | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/9/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial-Tan. | | 22b. DATE THEREOF
10/12/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Riverside | | 22d. LOCATION (City, town, or county) (State)
Penabscot City-Maine | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR
OCT 14 1957 | | 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

ILLINOIS STATE DEPARTMENT OF HEALTH - SPRINGFIELD, ILL.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|--|--|
| Name of Deceased | | MONTGOMERY | |
| Residence | | 810-5th Street, N.E., Washington, D.C. | |
| Place of Birth | | 810-5th Street, N.E., Washington, D.C. | |
| Age | | 38 | |
| Sex | | Male | |
| Race | | White | |
| Date of Death | | Dec. 1, 1957 | |
| Time of Death | | 11:00 A.M. | |
| Cause of Death | | Heart Disease | |
| Manner of Death | | Natural | |
| Signature of Examiner | | [Signature] | |
| Signature of Physician | | [Signature] | |
| Signature of Coroner | | [Signature] | |
| Signature of Medical Examiner | | [Signature] | |

RECEIVED
 OCT 14 1957
 BUREAU V. 2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10920

Reg. Dist. No.

214

10927

STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

| | | | | | |
|--|---|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN lb <u>D.O.A.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church</u> <u>83X-3</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Norwood Rd</u> | | | d. STREET ADDRESS <u>900 Ridge Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Leo Francis Paul</u> | | | 4. DATE OF DEATH <u>10-2-57</u> 19 | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-16-1915</u> 41 yrs. | | 9. AGE (In years last birthday) |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Force Officer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.F.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Iowa</u> | |
| 13. FATHER'S NAME <u>Elmer E Paul</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes Active</u> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | | 17. INFORMANT <u>U.S.A.F. Records</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>multiple injuries & trauma</u>
<u>860X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Body badly mutilated & burned</u>
DUE TO
(c) | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>aviation accident</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>2</u> p.m. <u>10-2</u> 1957 | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ruby Farm</u> | | 20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Brosch</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | <u>10-2-57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-7-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u> | | ADDRESS <u>377 11th St S.E. Wash., D.C.</u> | | 24a. REC'D BY REGISTRAR <u>1957</u> 24b. REGISTRAR'S SIGNATURE <u>Frances Catterp</u> | |

STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------------|--|--------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF MEDICAL EXAMINER | | 17. SIGNATURE OF JURY | | 18. SIGNATURE OF JURY | |
| 19. SIGNATURE OF JURY | | 20. SIGNATURE OF JURY | | 21. SIGNATURE OF JURY | |
| 22. SIGNATURE OF JURY | | 23. SIGNATURE OF JURY | | 24. SIGNATURE OF JURY | |
| 25. SIGNATURE OF JURY | | 26. SIGNATURE OF JURY | | 27. SIGNATURE OF JURY | |
| 28. SIGNATURE OF JURY | | 29. SIGNATURE OF JURY | | 30. SIGNATURE OF JURY | |
| 31. SIGNATURE OF JURY | | 32. SIGNATURE OF JURY | | 33. SIGNATURE OF JURY | |
| 34. SIGNATURE OF JURY | | 35. SIGNATURE OF JURY | | 36. SIGNATURE OF JURY | |
| 37. SIGNATURE OF JURY | | 38. SIGNATURE OF JURY | | 39. SIGNATURE OF JURY | |
| 40. SIGNATURE OF JURY | | 41. SIGNATURE OF JURY | | 42. SIGNATURE OF JURY | |
| 43. SIGNATURE OF JURY | | 44. SIGNATURE OF JURY | | 45. SIGNATURE OF JURY | |
| 46. SIGNATURE OF JURY | | 47. SIGNATURE OF JURY | | 48. SIGNATURE OF JURY | |
| 49. SIGNATURE OF JURY | | 50. SIGNATURE OF JURY | | 51. SIGNATURE OF JURY | |
| 52. SIGNATURE OF JURY | | 53. SIGNATURE OF JURY | | 54. SIGNATURE OF JURY | |
| 55. SIGNATURE OF JURY | | 56. SIGNATURE OF JURY | | 57. SIGNATURE OF JURY | |
| 58. SIGNATURE OF JURY | | 59. SIGNATURE OF JURY | | 60. SIGNATURE OF JURY | |
| 61. SIGNATURE OF JURY | | 62. SIGNATURE OF JURY | | 63. SIGNATURE OF JURY | |
| 64. SIGNATURE OF JURY | | 65. SIGNATURE OF JURY | | 66. SIGNATURE OF JURY | |
| 67. SIGNATURE OF JURY | | 68. SIGNATURE OF JURY | | 69. SIGNATURE OF JURY | |
| 70. SIGNATURE OF JURY | | 71. SIGNATURE OF JURY | | 72. SIGNATURE OF JURY | |
| 73. SIGNATURE OF JURY | | 74. SIGNATURE OF JURY | | 75. SIGNATURE OF JURY | |
| 76. SIGNATURE OF JURY | | 77. SIGNATURE OF JURY | | 78. SIGNATURE OF JURY | |
| 79. SIGNATURE OF JURY | | 80. SIGNATURE OF JURY | | 81. SIGNATURE OF JURY | |
| 82. SIGNATURE OF JURY | | 83. SIGNATURE OF JURY | | 84. SIGNATURE OF JURY | |
| 85. SIGNATURE OF JURY | | 86. SIGNATURE OF JURY | | 87. SIGNATURE OF JURY | |
| 88. SIGNATURE OF JURY | | 89. SIGNATURE OF JURY | | 90. SIGNATURE OF JURY | |
| 91. SIGNATURE OF JURY | | 92. SIGNATURE OF JURY | | 93. SIGNATURE OF JURY | |
| 94. SIGNATURE OF JURY | | 95. SIGNATURE OF JURY | | 96. SIGNATURE OF JURY | |
| 97. SIGNATURE OF JURY | | 98. SIGNATURE OF JURY | | 99. SIGNATURE OF JURY | |
| 100. SIGNATURE OF JURY | | 101. SIGNATURE OF JURY | | 102. SIGNATURE OF JURY | |

RECEIVED
OCT 7 1957
BUREAU V. S.

W. W. CHAMBERS CO. 222 N. B. ST. BALTIMORE 18

10921

10928

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Illinois
b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
55 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
The Clinical Center | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Morton Grove 51X-3 | | | |
| f. STREET ADDRESS
8917 North Marion Street | | | | g. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) | | First
Evelyn | | Middle
Judith | | Last
Pearlstein | |
| 4. DATE OF DEATH | | Month
October | | Day
8th | | Year
19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 7, 1927 | | 9. AGE (In years last birthday)
30 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Illinois | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Sam Goldsmith | | | | 14. MOTHER'S MAIDEN NAME
Lana Weiss | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
Not available | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Metastases from chorio carcinoma.
174X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chorio carcinoma of the uterus
DUE TO (c) 6 mos. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 14, 19 57 , to October 8, 19 57 , that I last saw the deceased alive on October 8, 19 57 , and that death occurred at 11:15 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Charles F. Nadler M.D. | | | | ADDRESS (Street, city or town, state)
The Clinical Center | | DATE SIGNED
10/8/57 | |
| PHYSICIAN'S NAME (Type) Charles F. Nadler, M. D. | | | | The National Institutes of Health
Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State)
Chicago Illinois | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
B Danganey & Sons | | | | ADDRESS
3501-14th Ave | | 24a. REC'D BY REGISTRAR
DATE 11 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10929 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Items 8, 9 Film G221 10-21-57 et
Reg. Dist. No. 10922 217

| | | | |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney
c. LENGTH OF STAY IN lb 3 1/2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County General | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Silver Spring R - 2
d. STREET ADDRESS Colesville-Beltsville Rd.
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Raymond Pearson Jr. | | 4. DATE OF DEATH 10/4/57 | |
| 5. SEX male | 6. COLOR OR RACE col. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/5/29 1929 |
| 9. AGE (In years last birthday) 28 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Va. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Raymond Pearson | |
| 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Record | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
DUE TO Hemorrhage
Conditions, if any, which gave rise to immediate cause (b) Shot gun wound thru liver
causing the underlying cause lost. (c) Shot gun wound thru liver | | INTERVAL BETWEEN ONSET AND DEATH
3 1/2 hrs
4 3/4 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rt. kidney also injured | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in argument with another party | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 6:25 a.m. 10/4/57 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm | | 20f. (City or town) Silver Spr ng Montg Md. (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 10/5/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Buried | | 22b. DATE THEREOF 10/8/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Queens Chapel, | | 22d. LOCATION (City, town, or county) Mirkirk, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Shordley | | ADDRESS Rockville, Md. | |
| 24a. REC'D BY REGISTRAR OCT 8 1957 | | 24b. REGISTRAR'S SIGNATURE Gertude L. Loney | |

OCT 8 1957

BUREAU V. S.

—

67

• For

NOTES

10930

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|------------------|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE District of Columbia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
26 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | e. STREET ADDRESS
939 Longfellow Street, N.W. | | | |
| 3. NAME OF DECEASED (Type or print)
First Jacob Middle (none) Last Perlman | | | | 4. DATE OF DEATH
Month October Day 14 , Year 19 57 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 15, 1889 | | 9. AGE (In years last birthday)
68 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Building | | 11. BIRTHPLACE (State or foreign country)
Russia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Isaac Perlman | | | | 14. MOTHER'S MAIDEN NAME
Rebecca Smith | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
050-05-7775 | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 162 X Bronchogenic carcinoma & metastasis to liver, ribs, vertebra, left clavicle
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Multiple abscesses - left lung
Fibrous pericarditis
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
28 months
?
2 | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from September 18, 19 57 , to October 14, 19 57 , that I last saw the deceased alive on October 14, 19 57 , and that death occurred at 3:20 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10-14-57
NATIONAL INSTITUTES OF HEALTH
Bethesda 14, Maryland | | | | | | | |
| ACTUAL SIGNATURE D. L. Kinsey, M.D. M.D. | | | | PHYSICIAN'S NAME (Type) D. L. Kinsey, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10/15/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Geo. Wash. Mem. Cem. | | 22d. LOCATION (City, town, or county) (State)
Hyattsville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Grady Funeral Home ADDRESS 4217-9 25th Ave. | | | | 24a. REC'D BY REGISTRAR
DATE 10-16-57 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| <p>1. NAME OF DECEASED
 JAMES H. HARRIS</p> | | <p>2. SEX
 Male</p> | |
| <p>3. AGE
 68</p> | | <p>4. DATE OF BIRTH
 1889</p> | |
| <p>5. PLACE OF BIRTH
 Baltimore, Md.</p> | | <p>6. OCCUPATION
 Retired</p> | |
| <p>7. MARITAL STATUS
 Married</p> | | <p>8. DATE OF MARRIAGE
 1915</p> | |
| <p>9. NAME OF SPOUSE
 Mary H. Harris</p> | | <p>10. DATE OF DEATH
 1957</p> | |
| <p>11. PLACE OF DEATH
 Baltimore, Md.</p> | | <p>12. CAUSE OF DEATH
 Heart Disease</p> | |
| <p>13. MEDICAL HISTORY
 Hypertension, Atherosclerosis</p> | | <p>14. SIGNATURE OF PHYSICIAN
 J. H. Harris</p> | |
| <p>15. SIGNATURE OF REGISTRAR
 J. H. Harris</p> | | <p>16. DATE OF REGISTRATION
 1957</p> | |

BUREAU V. 3

OCT 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10924

Reg. Dist. No.

216

10931

| | | | |
|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> | | d. STREET ADDRESS <u>1 818 RICHMOND ST.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>FREDERICK</u> Middle <u>DEAN</u> Last <u>PETERS</u> | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>25</u> Year <u>1957</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV. 10 1910</u> |
| 9. AGE (In years last birthday) <u>46</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUDITOR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. INFORMATION</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>WASH DC</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>Frederick Peters</u> | | 14. MOTHER'S MAIDEN NAME <u>Francis Phillips</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Nellie McBane</u> | | Address <u>1403 Merrimack Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>GASTRIC HEMORRHAGE</u>
<u>581.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CIRRHOSIS OF LIVER</u>
DUE TO (c) <u>CHRONIC ALCOHOLISM</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 hours</u>
<u>2 years</u>
<u>10 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal ULCER</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. m. p. m. Month, Day, Year 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1950</u> , to <u>25 OCT.</u> , 19 <u>57</u> that I last saw the deceased alive on <u>25 OCT.</u> , 19 <u>57</u> , and that death occurred at <u>1:14 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>L.B. Snow</u> | | ADDRESS (Street, city or town, state) <u>9013 FLOWER AVE SILVER SPRING, MD.</u> DATE SIGNED <u>25 Oct. 1957</u> | |
| PHYSICIAN'S NAME (Type) <u>L. B. SNOW</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>10/28/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Werner C. Humphrey</u> | | 24a. REC'D BY REGISTRAR <u>Bessie Thompson</u> | |
| ADDRESS <u>SILVER SPRING, MD.</u> | | DATE <u>OCT 29 1957</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. 0-10-10

| | | | | | | | | | | | | | | | |
|------------------|--|-------------------|--|------------------|--|-------------------|--|---------------------|--|-------------------|--|--------------------|--|------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| | | | | | | | | | | | | | | | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | |
| | | | | | | | | | | | | | | | |
| OCCUPATION | | EDUCATION | | RELIGION | | MARRIAGE | | SINGLE | | MARRIED | | WIDOWED | | DIVORCED | |
| | | | | | | | | | | | | | | | |
| DATE OF MARRIAGE | | PLACE OF MARRIAGE | | CITY OF MARRIAGE | | STATE OF MARRIAGE | | COUNTRY OF MARRIAGE | | CAUSE OF MARRIAGE | | MANNER OF MARRIAGE | | | |
| | | | | | | | | | | | | | | | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | |
| | | | | | | | | | | | | | | | |
| OCCUPATION | | EDUCATION | | RELIGION | | MARRIAGE | | SINGLE | | MARRIED | | WIDOWED | | DIVORCED | |
| | | | | | | | | | | | | | | | |
| DATE OF MARRIAGE | | PLACE OF MARRIAGE | | CITY OF MARRIAGE | | STATE OF MARRIAGE | | COUNTRY OF MARRIAGE | | CAUSE OF MARRIAGE | | MANNER OF MARRIAGE | | | |
| | | | | | | | | | | | | | | | |

BUREAU V. E.

OCT 29 1957

RECEIVED

10800

CERTIFICATE OF DEATH

10925, 73
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
<i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE
<i>Maryland</i> | | b. COUNTY
<i>Prince Georges</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Takoma Park</i> | | c. LENGTH OF STAY IN 1b
<i>6 hrs.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Hyattsville</i> | | <i>1615-2</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Washington San & Hospital</i> | | | | d. STREET ADDRESS
<i>8001 Riggs Rd</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) | | First
<i>William</i> | | Middle
<i>Mae</i> | | Last
<i>Phelps</i> | |
| 5. SEX
<i>Female</i> | | 6. COLOR OR RACE
<i>Cauc.</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>3-15-1900</i> | |
| 9. AGE (In years last birthday)
<i>57</i> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | |
| 10b. KIND OF BUSINESS OR INDUSTRY
<i>Hsw & maxm</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>Joseph Bladan</i> | |
| 14. MOTHER'S MAIDEN NAME
<i>Rechal husby</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<i>-</i> | | 16. SOCIAL SECURITY NO.
<i>-</i> | | 17. INFORMANT
<i>Hospital Records</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
<i>416X</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO
(c) | | Acute Congestive Cardiac Failure
<i>Rheumatic Heart disease</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>Terminal</i>
<i>40 yrs ±</i> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Hour o. m. p. m.
<i>19</i> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) | | 21. I certify that I attended the deceased from <i>10-3-1957</i> , to <i>10-4-1957</i> , that I last saw the deceased alive on <i>10-3-1957</i> , and that death occurred at <i>4:15 A.M.</i> , from the causes and on the date stated above.
<i>Has been under regular medical care two years.</i>
ADDRESS (Street, city or town, state)
DATE SIGNED
<i>Robert A. Hare</i>
<i>Takoma Park, Md.</i>
<i>10/4/57</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>10/7/57</i> | | 22c. NAME OF CEMETERY OR CREMATORY
<i>George Washington</i> | | 22d. LOCATION (City, town, or county)
<i>Hyattsville Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>F. Busch's sons</i> | | ADDRESS
<i>Hyattsville Md</i> | | 24a. REC'D BY REGISTRAR
<i>10/11/57</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Johnson</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10801

CERTIFICATE OF DEATH

1092673

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK | | c. LENGTH OF STAY IN 1b
26 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
17 TAKOMA PARK | | d. STREET ADDRESS
222 PARK AVE. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington San. & Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MAHLON Middle GEORGE Last PHOEBUS | | 4. DATE OF DEATH
Month OCTOBER Day 30 Year 19 57 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/16/71 |
| 9. AGE (In years last birthday)
86 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SUPERVISOR, Highway Construction | | 10b. KIND OF BUSINESS OR INDUSTRY
MARYLAND | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JAMES RUFUS PHOEBUS | | 14. MOTHER'S MAIDEN NAME
MARY P. ENGLISH | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
YES | | 16. SOCIAL SECURITY NO.
Sp. American | |
| 17. INFORMANT
Mrs. Mildred Burr, 220 Park Ave., Takoma Park, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident
DUE TO Anterior Cerebral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491x
(b) ?
(c) ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Terminal Broncho Pneumonia | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 4, 1957 to Oct 30, 1957 , that I last saw the deceased alive on Oct 29, 1957 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 4601-16 St, Takoma Park DATE SIGNED Phoebe Spire
ACTUAL SIGNATURE Phoebe Spire M.D. 4601-16 St, Takoma Park
PHYSICIAN'S NAME (Type) R. L. L. SPIRE | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
11/2/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
PROSPECT HILL CEMETERY | | 22d. LOCATION (City, town, or county) (State)
WASHINGTON, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Warner E. Humphrey | | ADDRESS
SILVER SPRING, MD. | |
| 24a. REC'D BY REGISTRAR
NOV 4 1957 | | 24b. REGISTRAR'S SIGNATURE
William D. Dadd | |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|--|--|
| 1. NAME OF DECEASED
JAMES EARL RAY | | 2. SEX
Male | | 3. AGE
35 Years | |
| 4. DATE OF DEATH
April 4, 1968 | | 5. TIME OF DEATH
2:01 PM | | 6. PLACE OF DEATH
Room 308, Airport Hotel, Memphis, Tennessee | |
| 7. CAUSE OF DEATH
Suicide by gunshot | | 8. MANNER OF DEATH
Homicide | | 9. PLACE OF BIRTH
Jackson, Mississippi | |
| 10. OCCUPATION
Member of the Senate | | 11. EDUCATION
High School Graduate | | 12. RELIGION
Methodist | |
| 13. MARITAL STATUS
Single | | 14. PREVIOUS MARRIAGES
None | | 15. SIGNATURE OF DECEASED
(Signature) | |
| 16. SIGNATURE OF WITNESS
(Signature) | | 17. SIGNATURE OF PHYSICIAN
(Signature) | | 18. SIGNATURE OF CORONER
(Signature) | |
| 19. SIGNATURE OF MEDICAL EXAMINER
(Signature) | | 20. SIGNATURE OF JURY
(Signature) | | 21. SIGNATURE OF JUDGE
(Signature) | |
| 22. SIGNATURE OF DISTRICT ATTORNEY
(Signature) | | 23. SIGNATURE OF COUNTY CLERK
(Signature) | | 24. SIGNATURE OF STATE CLERK
(Signature) | |

RECEIVED
NOV 4 1957
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

10932

10922216

| | | | | | | | |
|--|---|--|---|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Charles | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Port Tobacco 08x0.2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS
No street address | | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Maxwell Last Proctor | | | | 4. DATE OF DEATH
Month October Day 22 Year 19 57 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 17, 1929 | | 9. AGE (In years last birthday)
28 yrs. | IF UNDER 1 YEAR
Months 28 Days 0 | IF UNDER 24 HRS.
Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Clement Proctor | | | | 14. MOTHER'S MAIDEN NAME
Mary Alberta Harley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
215-36-3776 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia - b. lateral
491x DUE TO
Conditions, if any, which gave rise to immediate cause (b) 491x
(a), stating the underlying cause last. DUE TO (c) 491x | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Involved in auto accident enroute to hosp - no inquiry | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY
Hour 19 a. m. 19 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Bel Air | | (County)
Calvert | (State)
Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Brosch | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 10-22-57 | |
| EXAMINER'S NAME (Type) FRANK J. Brosch | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Oct 26, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Ignatius | | 22d. LOCATION (City, town, or county) (State)
Bel Air Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hunt & Funeral Home, Waldorf, Md. | | | | 24a. REC'D BY REGISTRAR
10/25/57 | | 24b. REGISTRAR'S SIGNATURE
Julia H. [Signature] | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

1957 99 CT 99

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10933

CERTIFICATE OF DEATH

Reg. Dist. No.

10928
217

| | | | |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | c. LENGTH OF STAY IN 1b
14 hrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Montgomery Co. General Hospital, Inc. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
James Willie Ramey | | 4. DATE OF DEATH
Month October Day 30 Year 19 57 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/6/74 |
| 9. AGE (In years last birthday)
83 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Coal Miner | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Ramey | | 14. MOTHER'S MAIDEN NAME
Sally Adams | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Hospital Record | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 480X Broncho-Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Influenza
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
3 days
10 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. j. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/29/57 , 19 57 , to 10/30/57 , 19 57 , that I last saw the deceased alive on 10/29/57 , 19 57 , and that death occurred at 1:00A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. W. Bird | | DATE SIGNED 10/30/57 | |
| PHYSICIAN'S NAME (Type)
J. W. Bird, M. D. | | ADDRESS (Street, city or town, state)
Sandy Spring, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
NOV 3, 57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Family Cemetery | | 22d. LOCATION (City, town, or county) (State)
Wise Co Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
ROY W. BARBER | | 24a. REC'D BY REGISTRAR
LAYTONSVILLE | |
| 24b. REGISTRAR'S SIGNATURE
Bertrude B Lander | | DATE 11-4-57 | |

Vision 2000?

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BUREAU V. S.

NOV 8 1957

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5-2-4-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10929

772

10802

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE D.C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
7300 Baltimore Avenue Cedar Haven Rest Home | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington 47X-3 | | | |
| d. STREET ADDRESS
736 Aspen Street, N.W. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Eleanor S. Reichard | | | | 4. DATE OF DEATH Month Day Year
October 29, 19 57 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/31/1880 | 9. AGE (In years lost birthday) yrs.
77 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY
State Department | | 11. BIRTHPLACE (State or foreign country)
New York | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Eugene -- | | | | 14. MOTHER'S MAIDEN NAME
--- Percy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
--- | | 16. SOCIAL SECURITY NO.
--- | | 17. INFORMANT Address
Ernest P. Sanford - 736 Aspen St., N.W. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year
19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from July 1, 19 57 to October 29, 19 57 , that I last saw the deceased alive on Oct. 28, 19 57 , and that death occurred at 10:00 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
A. B. Little | | M.D. 6911 | | ADDRESS (Street, city or town, state)
5th St. N.W. | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type)
A. B. LITTLE, MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | 22b. DATE THEREOF
10/31/57 | 22c. NAME OF CEMETERY OR CREMATORY
Pine Banks | | 22d. LOCATION (City, town, or county) (State)
Cheshire, New York | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H. Hines Co. | | ADDRESS
Wash. D.C. 14th St., N.W. | | 24a. REC'D BY REGISTRAR
OCT 30 1957 | 24b. REGISTRAR'S SIGNATURE
<i>J. Hines</i> | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|-----------------------|--|------------------------|--|------------------------|--|-------------------------|--|---------------------------|--|-------------------------------|--|-----------------------------------|--|-----------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| RACE | | RELIGION | | EDUCATION | | OCCUPATION | | MARRIED | | SINGLE | | WIDOW | | DIVORCED | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | CAUSE OF DEATH | | MANNER OF DEATH | |
| DIAGNOSIS | | TREATMENT | | HISTORY | | SYMPTOMS | | SIGNS | | LABORATORY | | PATHOLOGICAL | | FORENSIC | |
| FAMILY HISTORY | | SOCIAL HISTORY | | PERSONAL HISTORY | | MEDICAL HISTORY | | SURGICAL HISTORY | | DENTAL HISTORY | | PSYCHIATRIC HISTORY | | SUBSTANCE ABUSE HISTORY | |
| PHYSICIAN'S SIGNATURE | | PHYSICIAN'S NAME | | PHYSICIAN'S ADDRESS | | PHYSICIAN'S CITY | | PHYSICIAN'S STATE | | PHYSICIAN'S COUNTRY | | PHYSICIAN'S LICENSE NO. | | PHYSICIAN'S EXPIRATION DATE | |
| CORONER'S SIGNATURE | | CORONER'S NAME | | CORONER'S ADDRESS | | CORONER'S CITY | | CORONER'S STATE | | CORONER'S COUNTRY | | CORONER'S LICENSE NO. | | CORONER'S EXPIRATION DATE | |
| DEATH CERTIFICATE NO. | | DEATH CERTIFICATE DATE | | DEATH CERTIFICATE CITY | | DEATH CERTIFICATE STATE | | DEATH CERTIFICATE COUNTRY | | DEATH CERTIFICATE LICENSE NO. | | DEATH CERTIFICATE EXPIRATION DATE | | DEATH CERTIFICATE SIGNATURE | |

BUREAU V. L.

OCT 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10930

10934

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 218

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Germantown (rural)</u> | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>x2 Germantown (rural)</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>RFD # 1</u> | | | | d. STREET ADDRESS
<u>1 RFD # 1</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Paul</u> Middle <u>Xavier</u> Last <u>Reid</u> | | | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>11</u> Year <u>1957</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7/3/51 1895</u> | | 9. AGE (In years last birthday)
<u>62</u> yrs. | 10. UNDER 1 YEAR
Months <u> </u> Days <u> </u> | 11. UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>retired</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>James C. Reid</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Anna Browning</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u> </u> | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>Lucy Reid (wife)</u> | | Address
<u>Item 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage & Laceration</u>
<u>976X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Shot gun wound thru skull</u>
(c) <u> </u>
DUE TO
(c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Self inflicted shot gun wound</u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/11/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10-14-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Marys</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Barnesville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Ernest C. Gartner, Gaithersburg, Md.</u> | | | | 24a. REC'D BY REGISTRAR
<u>Oct. 14-57</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Abraham J. Cook</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

OCT 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10931

10935
Items 14 & 22b-Film G-222 11/12/57.cac
CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
o. STATE Maryland
b. COUNTY 10034 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. LENGTH OF STAY IN 1b
3 hr.35 min. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
26 Rockville | |
| d. STREET ADDRESS
917 Maple Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Tina Middle Marie Last REISTROFFER | | 4. DATE OF DEATH
Month October Day 21 Year 19 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
21 Oct. 1957 |
| 9. AGE (In years lost birthday) yrs.
3 | | IF UNDER 1 YEAR
Months 3 Days 35 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
James Eugene REISTROFFER | | 14. MOTHER'S MAIDEN NAME
Marjorie HOUCK/ EMBAUGH | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
(Father) James E. REISTROFFER (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Erythroblastosis Foetalis
DUE TO and
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity
DUE TO (c) 3 hr 35 min | | INTERVAL BETWEEN ONSET AND DEATH
3 hr 35 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 21 Oct. 1957 , to 21 Oct. 19 57 , that I last saw the deceased alive on 21 Oct. 19 57 , and that death occurred at 10:35 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 10-21-57 | | | |
| ACTUAL SIGNATURE Kenneth W. Sell M.D. | | U.S. Naval Hospital, Bethesda, Md. 10-21-57 | |
| PHYSICIAN'S NAME (Type) K.W. SELL LT MC USN | | U.S. Naval Hospital, Bethesda, Md. 10-21-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10-25-57 | 22c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cemetery | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R.A. Pumphrey | | 24a. REC'D BY REGISTRAR
DATE 10-21-57 | |
| 24b. REGISTRAR'S SIGNATURE
Mary E. Carrelly | | | |

2051273XV2

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

OCT 23 1957

RECEIVED

10936

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MD. b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
56 Silver Spring | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1806 Sherwood Road | | | | d. STREET ADDRESS
1806 Sherwood Road | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Allen Middle Burrows Last Reppert | | | | 4. DATE OF DEATH
Month Oct. Day 5 Year 1957 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 31, 1916 | |
| 9. AGE (In years last birthday)
41 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrical Engineer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Texas | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Phillip Lyman Reppert | | | | 14. MOTHER'S MAIDEN NAME
Margaret Burrows | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
yes (If yes, give war or date of service)
WW # 2 | | | | 17. INFORMANT
Ruth E. Reppert 1806 Sherwood Rd., SS., MD | | | |
| 16. SOCIAL SECURITY NO. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____
DUE TO (c) _____
INTERVAL BETWEEN ONSET AND DEATH
1 hour | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour o. m. _____ p. m. _____
Month. _____ Day. _____ Year. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from 20 July , 1957, to 5 Oct , 1957, that I last saw the deceased alive on 5 Oct , 1957, and that death occurred at 2:45 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 7112 Willow Ave DATE SIGNED 5 Oct
ACTUAL SIGNATURE M. B. Queen M.D. TAKOMA PARK, MD 1957.
PHYSICIAN'S NAME (Type) M. B. QUEEN | | | | | | | |
| 22a. BURIAL, CREMATION, REMAINS (Specify) burial | | 22b. DATE THEREOF 10/8/57 | | 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
Rockville Pike, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S. H. Hines Co., 2901 14th St. N.W. | | | | 24a. REC'D BY REGISTRAR
OCT 8 1957 | | 24b. REGISTRAR'S SIGNATURE
Frances Potters | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED
ALLEN, ALBERT | | 2. SEX
MALE | | 3. AGE
35 | |
| 4. OCCUPATION
LABORER | | 5. PLACE OF BIRTH
MARYLAND | | 6. DATE OF BIRTH
JAN 15 1892 | |
| 7. PLACE OF DEATH
BALTIMORE | | 8. CAUSE OF DEATH
HEART DISEASE | | 9. MEDICAL ATTENDANT
DR. J. H. HARRIS | |
| 10. DATE OF DEATH
OCT 8 1927 | | 11. TIME OF DEATH
10:30 AM | | 12. SIGNATURE OF DECEASED
ALBERT ALLEN | |
| 13. SIGNATURE OF WITNESSES
J. H. HARRIS, M.D.
J. H. HARRIS, M.D. | | 14. SIGNATURE OF PHYSICIAN
J. H. HARRIS, M.D. | | 15. SIGNATURE OF REGISTRAR
J. H. HARRIS, M.D. | |

BUREAU V. S.

OCT 8 1927

RECEIVED

10937

CERTIFICATE OF DEATH

Reg. Dist. No. 218

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montg MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg | | | | c. LENGTH OF STAY IN 1b 61 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. STREET ADDRESS 104 Chestnut St. | | | |
| 3. NAME OF DECEASED (Type or print)
First Harry Middle Clifford Last Riley | | | | 4. DATE OF DEATH
Month Oct Day 7 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Usg 24-1886 | |
| 9. AGE (In years last birthday) 61 yrs. | | IF UNDER 1 YEAR
Months 1 Days 13 Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperer & Decorater. | | | | 10b. KIND OF BUSINESS OR INDUSTRY Gaithersburg, Md. | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME William E. Riley | | | | 14. MOTHER'S MAIDEN NAME Annie M. Reed | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Aura D. Riley, 104 Chestnut St., Md Address Gaithersburg | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL METASTASIS
162X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC BRONCHITIS
DUE TO
(c) BRONCHIOGENIC CARCINOMA | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 HOURS
15 YEARS
6 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PULMONARY HYPERTROPHIC OSTEO ARTERIOPATHY | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 24, 1956 , to October 7, 1957 , that I last saw the deceased alive on October 7, 1957 , and that death occurred at 115A M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Gordon S. Rosenberger | | | | DATE SIGNED Oct 7, 1957 | | | |
| PHYSICIAN'S NAME (Type) Gordon S. Rosenberger | | | | ADDRESS (Street, city or town, state) GAITHERSBURG, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-9-57 | | 22c. NAME OF CEMETERY OR CREMATORY Kemptown | | 22d. LOCATION (City, town, or county) (State) Kemptown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md. | | | | 24a. REC'D BY REGISTRAR Oct 9-57 | | 24b. REGISTRAR'S SIGNATURE Abraham G. Coode | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|---|--|
| 1. NAME OF DECEASED
JOHN J. SMITH | | 2. SEX
Male | | 3. AGE
45 | |
| 4. PLACE OF BIRTH
BALTIMORE, MARYLAND | | 5. DATE OF BIRTH
JAN 15 1912 | | 6. DATE OF DEATH
OCT 11 1957 | |
| 7. STREET ADDRESS
1015 E. BAYVIEW | | 8. CITY
BALTIMORE | | 9. STATE
MARYLAND | |
| 10. OCCUPATION
Salesman | | 11. CAUSE OF DEATH
Myocardial Infarction | | 12. MANNER OF DEATH
Natural | |
| 13. SIGNATURE OF PHYSICIAN
J. H. SMITH, M.D. | | 14. SIGNATURE OF DECEASED
JOHN J. SMITH | | 15. SIGNATURE OF WITNESS
J. H. SMITH, M.D. | |
| 16. SIGNATURE OF REGISTRAR
J. H. SMITH, M.D. | | 17. SIGNATURE OF CLERK
J. H. SMITH, M.D. | | 18. SIGNATURE OF NURSE
J. H. SMITH, M.D. | |
| 19. SIGNATURE OF CHURCH CLERK
J. H. SMITH, M.D. | | 20. SIGNATURE OF MINISTER
J. H. SMITH, M.D. | | 21. SIGNATURE OF RABBI
J. H. SMITH, M.D. | |
| 22. SIGNATURE OF OTHER
J. H. SMITH, M.D. | | 23. SIGNATURE OF OTHER
J. H. SMITH, M.D. | | 24. SIGNATURE OF OTHER
J. H. SMITH, M.D. | |

BUREAU V. E.

OCT 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10938 16

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission)
a. STATE D. C.
b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Md. | | | | c. LENGTH OF STAY IN 1b
11 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Louis Middle (No middle name) Last Rispoli | | | | 4. DATE OF DEATH
Month October Day 24 Year 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
January 11, 1895 | |
| 9. AGE (In years last birthday)
62 yrs. | | IF UNDER 1 YEAR
Months 24 Days 19 Hours 57 | | IF UNDER 24 HRS.
Months 24 Days 19 Hours 57 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Barber | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Barber | | 10b. KIND OF BUSINESS OR INDUSTRY
Barbering | | 11. BIRTHPLACE (State or foreign country)
Italy | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Louis Rispoli | | | | 14. MOTHER'S MAIDEN NAME
Mary (Unknown) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown)
No | | 16. SOCIAL SECURITY NO.
Not available | | 17. INFORMATION
The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA
163X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) CARCINOMA OF LUNGS, BILATERAL
DUE TO
(c) 2 mos. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
PAY 5 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 14, 1957 , to October 24, 1957 , that I last saw the deceased alive on October 24, 1957 , and that death occurred at 7:00 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/25/57
NATIONAL INSTITUTES OF HEALTH
BETHESDA 14, MARYLAND | | | | | | | |
| ACTUAL SIGNATURE
Edward W. Moore | | M.D. Edward W. Moore, M.D. | | The Clinical Center | | 10/25/57 | |
| PHYSICIAN'S NAME (Type) | | Edward W. Moore, M.D. | | The Clinical Center | | 10/25/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-28-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 22d. LOCATION (City, town, or county) (State)
Silver Spring, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Francis Collins | | | | ADDRESS
3821-14th St. N.W. Wash. D.C. | | | |
| 24. RECEIVED BY REGISTRAR
Francis Collins | | | | 24b. REGISTRAR'S SIGNATURE
Francis Collins | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|------------------------|--|-----------------------|--|--------------------------|--|-------------------------|--|------------------------|--|--------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. HARRIS | | M | | 45 | | JAN 15 1910 | | BALTIMORE | | BALTIMORE | | MARYLAND | | UNITED STATES | |
| RACE | | COLOR | | RELIGION | | MARRIAGE | | EDUCATION | | OCCUPATION | | SPECIAL OCCUPATION | | MILITARY SERVICE | |
| WHITE | | WHITE | | METHODIST | | MARRIED | | HIGH SCHOOL | | LABORER | | | | | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | | POST-MORTEM | |
| JAN 28 1957 | | BALTIMORE | | HEART DISEASE | | NATURAL | | CORONARY ARTERY DISEASE | | PAIN IN CHEST | | MEDICINE | | NONE | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF CLERK | | SIGNATURE OF REGISTRAR | | SIGNATURE OF JUDGE | | SIGNATURE OF SHERIFF | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |

RECEIVED
JCT 28 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10939

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10935

Reg. Dist. No. 214

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b
<u>17 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>56 Silver Spring</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Home 521 Ashford Road</u> | | | | d. STREET ADDRESS
<u>521 Ashford Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Hugh</u> Middle <u>Rivers</u> Last <u>Rivers</u> | | | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>29</u> Year <u>1957</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Nov. 16, 1882</u> | |
| 9. AGE (In years last birthday)
<u>74</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Electrolytic plater)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Bureau of Engraving</u> | | | |
| 13. FATHER'S NAME
<u>JOHN L. Charles C. Rivers</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>LAVILLA A. GATEWOOD</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>No</u> | | 17. INFORMANT
<u>Hugh F. Rivers 521 Ashford Rd. Silver Spring</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u>
(a), stating the underlying cause last. DUE TO (c) <u>420.1</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>History of previous heart attacks</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Brochart</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Brochart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/29/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>11/2/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>GATE OF HEAVEN CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>MONTGOMERY COUNTY, MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner E. Humphrey</u> | | | | ADDRESS
<u>SILVER SPRING, MD.</u> | | 24. REC'D BY REGISTRAR
<u>1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Frances Potter</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. M.

OCT 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the reason for prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10936

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10940

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Iowa b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b
35 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Maryland | | | | d. STREET ADDRESS
512 High Ave. East. | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Jack Middle Willhoit Last ROE | | | | 4. DATE OF DEATH
Month October Day 26 Year 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1 July 1911 | |
| 9. AGE (In years last birthday)
46 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mariner | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy | | | |
| 11. BIRTHPLACE (State or foreign country)
Seattle, Washington | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | |
| 13. FATHER'S NAME
Charles C. ROE | | | | 14. MOTHER'S MAIDEN NAME
Clytie WILLHOIT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes (Currently) | | | | 16. SOCIAL SECURITY NO.
483 48 3218 | | | |
| 17. INFORMANT
(Wife) Mrs. Frances Merriam ROE (Same As #2) | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of stomach - metastasis
151X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) Interval between onset and death approx 1 yr. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 22 Sept. , 19 57 , to 26 Oct. , 19 57 , that I last saw the deceased alive on 26 Oct. , 19 57 , and that death occurred at 11:23 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
U. S. Naval Hospital, Bethesda, Md. 10-28-57 | | | | | | | |
| ACTUAL SIGNATURE
D.P. OSBORNE | | | | M.D. U. S. Naval Hospital, Bethesda, Md. 10-28-57 | | | |
| PHYSICIAN'S NAME (Type)
D.P. OSBORNE CAPT MC USN | | | | U. S. Naval Hospital, Bethesda, Md. 10-28-57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-31-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington Natl Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Chambers, 3042 "M" Street, N.W. Washington, D.C. | | | | 24a. REC'D BY REGISTRAR
DATE 10-28-57 | | 24b. REGISTRAR'S SIGNATURE
Mary E. Parrelly | |

BUREAU V. S.

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10937

10941

Item 2 Film 0221 10-25-57 et

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER Spring
c. LENGTH OF STAY IN lb 7 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Le Deau Gardens Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Pittsburgh
d. STREET ADDRESS 5537 5th Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Maurice Rosenberg | | 4. DATE OF DEATH Oct. 4, 1957 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN-22-1894 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silversmith | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Pa. |
| 13. FATHER'S NAME Jacob Rosenberg | | 14. MOTHER'S MAIDEN NAME Diana Baker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Nursing Home Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO Hypertention
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs.
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF OCT-6-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY BETH SHOLEN CON MILVALE, PA. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Sherman Gilling | | 24a. REC'D BY REGISTRAR DATE 11/7/57 | |
| 24b. REGISTRAR'S SIGNATURE Frances P. Miller | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU VI

OCT 10 1957

RECEIVED

10942

CERTIFICATE OF DEATH

Reg. Dist. No.

217

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>D. C.</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3 ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> | | | | d. STREET ADDRESS <u>3385 STEPHENSON PL.</u> NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ORA CAGE ROWLETT</u> | | | | 4. DATE OF DEATH Month Day Year <u>OCT 18 1957</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>APR. 9-1888</u> | |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL TEACHER</u> | | 11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>ADOLPHUS B. CAGE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARTHA ANN GRIGG</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>NO</u> | | 17. INFORMANT Address <u>MR. ALLEN ROWLETT - HUSBAND</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
<u>591X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic glomerulonephritis, subacute</u> DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>7 days</u>
<u>1 month</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatitis</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Jan</u> , 1957, to <u>17 OCT</u> , 1957, that I last saw the deceased alive on <u>17 OCT</u> , 1957, and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | | | DATE SIGNED | |
| ACTUAL SIGNATURE <u>Herbert Martyn Jr.</u> M.D. <u>5029 Bethesda Ave</u> <u>18 OCT 57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR.</u> <u>Bethesda, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/21/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Richmond, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> | | | | ADDRESS <u>Washington, D. C.</u> | | 24a. RECEIVED BY REGISTRAR <u>OCT 21 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Form No. 1

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED
JAMES H. HARRIS | | 2. SEX
Male | | 3. AGE
68 | | 4. DATE OF BIRTH
1889 | |
| 5. PLACE OF BIRTH
Baltimore, Md. | | 6. OCCUPATION
Retired | | 7. CAUSE OF DEATH
Heart Disease | | 8. MANNER OF DEATH
Natural | |
| 9. DATE OF DEATH
Oct 21 1957 | | 10. TIME OF DEATH
10:30 AM | | 11. PLACE OF DEATH
Home | | 12. SIGNATURE OF PHYSICIAN
J. H. Harris | |
| 13. SIGNATURE OF REGISTRAR
J. H. Harris | | 14. SIGNATURE OF WITNESSES
J. H. Harris | | 15. SIGNATURE OF FUNERAL HOME
J. H. Harris | | 16. SIGNATURE OF CLERGYMAN
J. H. Harris | |
| 17. SIGNATURE OF DECEASED
J. H. Harris | | 18. SIGNATURE OF NEXT OF KIN
J. H. Harris | | 19. SIGNATURE OF SURVIVORS
J. H. Harris | | 20. SIGNATURE OF OTHERS
J. H. Harris | |

BUREAU V. S.

OCT 21 1957

RECEIVED

10943

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
p. STATE Virginia b. COUNTY Arlington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
38 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | e. STREET ADDRESS
4412 North Henderson Road | | | |
| 3. NAME OF DECEASED (Type or print)
First Harry Middle Mitchell Last Rubin, Jr. | | | | 4. DATE OF DEATH
Month October Day 11 , Year 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
February 27, 1922 | |
| 9. AGE (In years last birthday)
35 yrs. | | 10. IF UNDER 1 YEAR
Months 35 Days 3 Hours 3 Min. | | 11. IF UNDER 24 HRS.
Months 35 Days 3 Hours 3 Min. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lawyer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Law - Self Employed | | | |
| 11. BIRTHPLACE (State or foreign country)
South Carolina | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Harry M. Rubin, Sr. | | | | 14. MOTHER'S MAIDEN NAME
Ruth Ensel | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes WW II | | | | 16. SOCIAL SECURITY NO.
None | | | |
| 17. INFORMANT
The Medical Record | | | | Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
710.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Scleroderma
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 min
18 mo. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
019 Miliary Tuberculosis | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 a. m. p. m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from September 3, 1957 , to October 11, 1957 , that I last saw the deceased alive on October 11, 1957 , and that death occurred at 1:10a M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Robert Edgar | | | | ADDRESS (Street, city or town, state)
The Clinical Center | | | |
| PHYSICIAN'S NAME (Type)
Robert Edgar, M. D. | | | | DATE SIGNED
10/11/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
10/15/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | |
| 22d. LOCATION (City, town, or county)
Arlington | | | | 22e. (State)
Virginia | | 22f. (Country) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph Bamberis | | | | ADDRESS
1756 Pennsylvania Ave NW | | 24a. REC'D BY REGISTRAR
ACT 14 1957 | |
| 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | | | | DATE
10/14/57 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10940

Reg. Dist. No.

214

10944

FOR STATE
HEALTH DEPT.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | c. LENGTH OF STAY IN <u>D.O.A.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u> | <u>16 x 2.2</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Nowood Rd</u> | | d. STREET ADDRESS <u>5076 Dunlap Street</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>William O Ruse</u> | 4. DATE OF DEATH <u>10-2-57</u> | Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-9-21</u> |
| 9. AGE (In years last birthday) <u>35</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Force Officer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. A. F</u> | 11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u> | | 13. FATHER'S NAME <u>William C Ruse</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Active</u> | |
| 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>U.S. A. F. Records</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Multiple Injuries Extreme</u>
860X DUE TO
Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) <u>Body badly mutilated + burned</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <u>Airplane Accident</u> | | |
| 20c. TIME OF INJURY Month, Day, Year <u>2</u> Hour <u>10-2</u> a.m. <u>19 57</u> p.m. | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Robey Farm</u> | 20f. (City or town) <u>Silver Spring Monty. Md</u> (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>10-2-57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-7-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>17th St. S.E., Wash. D.C.</u> | 22d. LOCATION (City, town, or county) <u>Tulsa Oklahoma</u> (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u> | | 24. REGISTRY BY <u>1957</u> 24b. REGISTRAR'S SIGNATURE <u>Frances Lett</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be kept for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF
DEATH

NAME OF DECEASED
SEX
AGE
DATE OF BIRTH

RESIDENCE
OCCUPATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IN RECORD

BUREAU V. S.

OCT 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10941

Reg. Dist. No.

215

10945

| | | | | | |
|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Michigan b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. LENGTH OF STAY IN 1b
15 min. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Highland Park | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
U.S. Naval Hospital, Bethesda, Md. | | | d. STREET ADDRESS
104 West Grand Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Oakley Middle Claude Last SEARLS | | | 4. DATE OF DEATH
Month October Day 5 Year 19 57 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
14 Jan. 1937 | | 9. AGE (In years last birthday)
20 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy | 11. BIRTHPLACE (State or foreign country)
Michigan | | 12. CITIZEN OF WHAT COUNTRY?
U.S. |
| 13. FATHER'S NAME
Claude SEARLS | | | 14. MOTHER'S MAIDEN NAME
Sadie Caroline (Last Name Unknown) (Deceased) | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes - Currently | | 16. SOCIAL SECURITY NO.
368 36 2694 | 17. INFORMANT
Official Navy Records Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subdural Hematoma, right
823X DUE TO
Conditions, if any, which gave rise to immediate cause (b) SKULL Skull fracture
(a), stating the underlying cause last. DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
4-$\frac{1}{2}$ Hours
4-$\frac{1}{2}$ hours |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Auto failed to negotiate curve hitting tree | | | |
| 20c. TIME OF INJURY
Hour 1:30 o. m. 10-5 19 57 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Street | | 20f. (City or town)
Tall Timbers, Maryland | (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Frank J. BROSCHEART | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 10-6-57 | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10-10-57 | 22c. NAME OF CEMETERY OR CREMATORY
Private Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hurricane, West Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R.A. Pumphrey | | ADDRESS
7557 Wisconsin Ave., Bethesda, Md. | | 24a. REC'D BY REGISTRAR
DATE 10-7-57 | 24b. REGISTRAR'S SIGNATURE
Mary B. Parrelly |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

OCT 8 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. ~~113~~ 215

10946

| | | | | | | | |
|---|----------------------------------|--|-------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Great Mills 18 x 2.2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS
18 x 2.2 | | | |
| 3. NAME OF DECEASED (Type or print)
First Ca rl Middle Anthony Last SEPPE | | | | 4. DATE OF DEATH
Month October Day 15 Year 19 57 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-14-57 | | 9. AGE (In years last birthday) yrs.
1 | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months 1 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Angelo L. SEPPE | | | | 14. MOTHER'S MAIDEN NAME
Olive NORRIS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Official Navy Records Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 750x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anencephaly DUE TO
(c) 24 hrs. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month. 19 Day. 19 Hour a. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 14 Oct. , 19 57 , to 15 Oct. , 19 57 , that I last saw the deceased alive on 15 Oct. , 19 57 , and that death occurred at 5:46 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Russell Miller, Jr. | | | | M.D. U.S. Naval Hospital, Bethesda, Md. 10-16-57 | | | |
| PHYSICIAN'S NAME (Type) Russell Miller, Jr., LT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-18-57 | | 22c. NAME OF CEMETERY OR CREMATORY
Little Flower Cemetery | | 22d. LOCATION (City, town, or county) (State)
Great Mills, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W.C. Mattingley | | | | ADDRESS
Leonardtwn, Md. | | 24a. REC'D BY REGISTRAR
DATE 10-16-57 | |
| 24b. REGISTRAR'S SIGNATURE
Mary E. Farrelly | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050302 XVI

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------|--|-----------------|--|----------------|--|------------------|--|----------------|--|----------------|--|---------------|--|----------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES H. HARRIS | | Male | | 45 | | 1880 | | Baltimore | | Maryland | | United States | | United States | |
| RACE | | COLOR | | RELIGION | | MARRIED | | SINGLE | | WIDOW | | DIVORCED | | OTHER | |
| White | | White | | Roman Catholic | | Married | | Single | | Widow | | Divorced | | Other | |
| OCCUPATION | | EDUCATION | | SCHOOLING | | REASON FOR DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | |
| Carpenter | | High School | | 12 | | Heart Disease | | 1927 | | Baltimore | | Maryland | | United States | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | OTHER | |
| Heart Disease | | Natural | | 1927 | | Baltimore | | Maryland | | United States | | United States | | Other | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | OTHER | | DATE OF DEATH | | PLACE OF DEATH | |
| 1927 | | Baltimore | | Maryland | | United States | | United States | | Other | | 1927 | | Baltimore | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | OTHER | | DATE OF DEATH | | PLACE OF DEATH | |
| 1927 | | Baltimore | | Maryland | | United States | | United States | | Other | | 1927 | | Baltimore | |

BUREAU V. S.

OCT 18 1927

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10947

CERTIFICATE OF DEATH

10943

Reg. Dist. No.

214

| | | | |
|--|-------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Washington, D.C.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Rest Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>E. Raymond Shepard</u> | | 4. DATE OF DEATH Month Day Year <u>October 17 19 57</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/3/80</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Utah</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Utah</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Rae Shepard</u> | | 14. MOTHER'S MAIDEN NAME <u>Josephine Lockley</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Elsie Shepard</u> | | Address <u>5425 Conn. Ave. N.W.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute HEART FAILURE</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC Heart Disease</u>
DUE TO (c) <u>10 yrs</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL THROMBOSIS 1950</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u> | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>JAN 1, 1949</u> to <u>OCT 17, 1957</u> that I last saw the deceased alive on <u>OCT 16, 1957</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Horace H. Custis, Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>1852 COLUMBIA RD WASH. 9, D.C.</u> | |
| DATE SIGNED <u>10/17/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>HORACE H. CUSTIS, JR.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF <u>10/19/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The SA Hines Co. 2901-14th St NW Wash., D.C.</u> | | 24a. REC'D BY REGISTRAR <u>21 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Frances Peltier</u> | | | |

BUREAU V. 5

OCT 21 1957

RECEIVED

The HH House Co. 289-1008

10948
BALTIMORE, 18
10944 214
Reg. Dist. No.
10948
10944 214
Reg. Dist. No.
10948
10944 214
Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>56 SILVER SPRING</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>FLORENCE LEONA SHIPLEY</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>10 25 1957</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>Cauc.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>4/7/1869</u> | |
| 9. AGE (In years last birthday) yrs.
<u>88</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>OLIVER THOMAS VAN HORNE</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>SARAH MULLIKIN</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>no</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>none</u> | | | | 17. INFORMANT
<u>MILDRED F. STAMM</u> Address <u>432 Longfellow St., N.W., D.C.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u>
<u>501x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHITIS</u> DUE TO
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19
<u>10 25 1957</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Oct. 24</u> , 19 <u>57</u> , to <u>Oct. 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 25</u> , 19 <u>57</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Eino Mägi</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>918 University Blvd. East 10/25/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>EINO MÄGI</u> | | | | Silver Spring, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10-28-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>George Wash. Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Riggs Road Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Deaf Funeral Home</u> | | | | ADDRESS
<u>4812 Ga Ave NW</u> | | 24a. REC'D BY REGISTRAR
<u>AT 28 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Francis Potter</u> | | | | | | | |

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

773

| | | | |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Mont. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
17 Takoma Park | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
321 Ethan Allen Avenue | | d. STREET ADDRESS
321 Ethan Allen Avenue | |
| 3. NAME OF DECEASED (Type or print) Jennie First Le Middle Short Last | | 4. DATE OF DEATH
Month 10 Day 8 Year 1957 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/3/1869 |
| 9. AGE (In years lost birthday) 88 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Deer Creek, Illinois | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Thomas A. Crane | | 14. MOTHER'S MAIDEN NAME
Emily M. Kingsbury | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Helen Stuntz-321 Ethan Allen Ave. | | Address Takoma Park, Md. | |

| | | |
|--|---|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Vascular Renal Disease
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis Generalized
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
5 years
10 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from April , 19 55 , to 8 Oct , 19 57 , that I last saw the deceased alive on 7 Oct , 19 57 , and that death occurred at 4:50 A.M. , from the causes and on the date stated above. | | |
| ADDRESS (Street, city or town, state)
2112 Willow Ave | | DATE SIGNED
8 Oct 1957 |
| ACTUAL SIGNATURE
M. B. Queen | | M.D. TAKOMA PARK MD |
| PHYSICIAN'S NAME (Type)
M. B. QUEEN | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10/11/57 | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery |
| 22d. LOCATION (City, town, or county) (State)
Prince Georges Co. Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H.Hines Co. Washington, D. C. | | 24a. REC'D BY REGISTRAR
00T 9 1957 |
| 24b. REGISTRAR'S SIGNATURE
J. H. Hines | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | | | |
|--|--|---|--|---|--|
| NAME OF DECEASED
[Faint text, possibly "John Doe"] | | SEX
[Faint text, possibly "Male"] | | DATE OF BIRTH
[Faint text, possibly "10/10/1900"] | |
| PLACE OF BIRTH
[Faint text, possibly "Baltimore, Md."] | | OCCUPATION
[Faint text, possibly "Clerk"] | | CAUSE OF DEATH
[Faint text, possibly "Heart Disease"] | |
| RESIDENCE
[Faint text, possibly "121 South Allen Avenue"] | | DATE OF DEATH
[Faint text, possibly "10/15/1957"] | | PLACE OF DEATH
[Faint text, possibly "Home"] | |
| SIGNATURE OF DECEASED
[Faint text, possibly "John Doe"] | | SIGNATURE OF WITNESS
[Faint text, possibly "John Doe"] | | SIGNATURE OF PHYSICIAN
[Faint text, possibly "John Doe"] | |
| SIGNATURE OF CORONER
[Faint text, possibly "John Doe"] | | SIGNATURE OF JURY
[Faint text, possibly "John Doe"] | | SIGNATURE OF JUDGE
[Faint text, possibly "John Doe"] | |

BUREAU V. 1

OCT 9 1957

RECEIVED

10949

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda x2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
5400 Greystone Street | | | | d. STREET ADDRESS
5400 Greystone Street | | | |
| 3. NAME OF DECEASED (Type or print)
First Edgall Middle Adams Last STOLZ | | | | 4. DATE OF DEATH
Month October Day 30 Year 57 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
Sept 14, 1883 | 9. AGE (In years last birthday)
74 yrs. | IF UNDER 1 YEAR
Months 1 Days 16 Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Missouri | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Edmond Hamilton Adams | | | | 14. MOTHER'S MAIDEN NAME
Carrie Hicks | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
567-30-5338 | | 17. INFORMANT
Comdr. T.B. Owen-above 2d | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Failure
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction
DUE TO (c) Coronary Artery Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 wks
15 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 10, 1957 to Oct. 30, 1957 that I last saw the deceased alive on Oct. 28, 1957 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Robert G Taylor | | | | ADDRESS (Street, city or town, state) Washington Clinic, Washington, DC DATE SIGNED 10/30/57 | | | |
| PHYSICIAN'S NAME (Type) Robert G. Taylor, M.D. | | | | 1150 Conn. Ave. N.W. Wash. D.C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 22b. DATE THEREOF
11/1/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 22d. LOCATION (City, town, or county) (State)
Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | ADDRESS
Bethesda, Maryland | | 24a. REC'D BY REGISTRAR
DATE 11-1-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

10950

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
80 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓
Hyattsville 16152 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS
2402 Hannon Street | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Judy Middle Gail Last Sundquist | | | | 4. DATE OF DEATH
Month October Day 31 Year 19 57 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
November 3, 1946 | |
| 9. AGE (In years last birthday)
10 yrs. | | IF UNDER 1 YEAR
Months 10 Days 15 Hours 2 Min. | | 11. BIRTHPLACE (State or foreign country)
Minnesota | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Minnesota | |
| 13. FATHER'S NAME
Lloyd L. Sundquist | | | | 14. MOTHER'S MAIDEN NAME
Florence Olafson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pontoreal Hemorrhage
204.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Thrombocytopenia
DUE TO
(c) Acute Lymphocytic Leukemia
INTERVAL BETWEEN ONSET AND DEATH
8 hours
1 mo.
6 mo. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 12, 1957 , to October 31, 1957 , that I last saw the deceased alive on October 31, 1957 , and that death occurred at 6:50 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/31/57
NATIONAL INSTITUTES OF HEALTH
Bethesda 14, Maryland | | | | | | | |
| ACTUAL SIGNATURE Dane R. Boggs M.D. | | | | PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | Nov. 2, 1957 | | Cedar Hill Cemetery | | Prince Georges County Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. Arthur Waller | | | | ADDRESS
254 Carroll St NW | | 24a. REC'D BY REGISTRAR
NOV 1 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | | | |

RECEIVED

10V 1 1957

BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10951

CERTIFICATE OF DEATH

10948 214

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
125 W. Notley Road | | | | d. STREET ADDRESS
125 W. Notley Road | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First JESSIE Middle M. Last SWAFFORD | | | | 4. DATE OF DEATH
Month October Day 2 Year 1957 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5/6/78 | |
| 9. AGE (In years last birthday)
79 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Practical Nurse | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Missouri | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Louis Blaetterman | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
360-07-8559A | | 17. INFORMANT
Mr. Joseph H. Swafford, 125 W. Notley Road | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Baragrene Left Foot + Lower Leg
450.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis Generalized
DUE TO
(c) 10 years | | | | INTERVAL BETWEEN ONSET AND DEATH
4 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Renal Insufficiency with Uremia | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
Silver Spring, Md | | | | 20g. (County)
Montgomery | | 20h. (State)
Md | |
| 21. I certify that I attended the deceased from 1 Sept , 19 57 , to 2 Oct , 19 57 , that I last saw the deceased alive on 1 Oct , 19 57 , and that death occurred at 9:20 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE M.B. Queen | | | | ADDRESS (Street, city or town, state)
7112 Willow Ave Takoma Park, Md | | | |
| PHYSICIAN'S NAME (Type)
M.B. QUEEN | | | | DATE SIGNED
30 Oct 1957 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION | | 22b. DATE THEREOF
10/2/57 | | 22c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CREMATORY | | 22d. LOCATION (City, town, or county) (State)
PRINCE GEORGE COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Warner C. Humphrey | | | | ADDRESS
SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR
OCT 4 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Frances Patter | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|----------------------|--|-------------------|--|------------------------|--|-----------------------|--|--------------------------|--|--------------------|--|----------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| MARRIAGE | | MARRIED | | SINGLE | | WIDOW | | DIVORCED | | SEPARATED | | OTHER | | | |
| OCCUPATION | | PROFESSION | | INDUSTRY | | BUSINESS | | ART | | SCIENCE | | LITERATURE | | OTHER | |
| EDUCATION | | SCHOOL | | COLLEGE | | UNIVERSITY | | OTHER | | DEGREE | | HONOR | | OTHER | |
| RELIGION | | METHODIST | | ROMAN CATHOLIC | | LUTHERAN | | PRESBYTERIAN | | BAPTIST | | OTHER | | | |
| CAUSE OF DEATH | | DISEASE | | INJURY | | POISON | | OTHER | | MANNER OF DEATH | | SUICIDE | | HOMICIDE | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | HOSPITAL | | OTHER | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF JURY | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF OTHER | | | |

BUREAU V. S.

OCT 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10949

Reg. Dist. No. 216

10952

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase x2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4007 Thornapple Street | | | | d. STREET ADDRESS
4007 Thornapple Street | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) ELMER First Middle Last | | | | 4. DATE OF DEATH THOMPSON Month Day Year October 25, 1957 19 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 28, 1890 | |
| 9. AGE (In years last birthday)
67 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
1 17 | | IF UNDER 24 HRS.
17 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. - | | 10b. KIND OF BUSINESS OR INDUSTRY
Agriculture Dep. | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
Luther H. Thompson | | | | 14. MOTHER'S MAIDEN NAME
Mollie Badee | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
WW 1 | | 17. INFORMANT
Jennie A. Thompson-Item# 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Failure
442x DUE TO due to chronic cardio renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ?
DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH
12 hrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/25/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/29/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 10-26-57 | | 24b. REGISTRAR'S SIGNATURE
T. Bessie M. Hooten | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|--|--|
| Name of Deceased
Robert A. Humphrey-Barnes, Md. | | Date of Death
10/28/57 | | Place of Death
Arlington National | |
| Age
41 | | Sex
Male | | Race
White | |
| Marital Status
Married | | Occupation
Engineer | | Cause of Death
Acute Cardiac Failure | |
| Contributing Cause
due to chronic cardiac renal disease | | Manner of Death
Natural | | Signature of Medical Examiner
Mollie Barnes | |
| Signature of Coroner
J. H. Thompson | | Signature of Physician
J. H. Thompson | | Signature of Medical Examiner
Mollie Barnes | |
| Address
214-38-4717 Jennie A. Thompson-Humphrey 3 | | City
Baltimore | | State
Maryland | |
| County
Chesapeake | | City
Chesapeake | | State
Maryland | |
| Address
1807 Thompson Street | | City
Baltimore | | State
Maryland | |
| Date of Death
October 28, 1957 | | Time of Death
10:30 PM | | Place of Death
Arlington National | |

RECEIVED
 OCT 28 1957
 BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10953

CERTIFICATE OF DEATH

10950

Reg. Dist. No. 216

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b <u>7 hrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 CHEVY CHASE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | | | d. STREET ADDRESS <u>13 PRIM ROSE ST.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>First Emilija Middle Tifental</u> | | | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>19</u> Year <u>1957</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. B. DATE OF BIRTH <u>1902</u> 9. AGE (In years lost birthday) <u>55</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>LATVIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>DIETRICH TIFENTALS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>217-3881169</u> | | 17. INFORMANT <u>Mrs Geo. W. GARAND</u> | | Address <u>- Same 2d</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
DUE TO <u>Possible Aneurysm of cerebral artery.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u>
DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible gall bladder disease</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10/18</u> , 19 <u>57</u> , to <u>10/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/18</u> , 19 <u>57</u> , and that death occurred at <u>6:05 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>James J. Foster</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>1746 K St N.W.</u> | | | |
| DATE SIGNED <u>10/21/57</u> | | | | | | | |
| 22a. BURIAL, CREMATION, <u>Cremation</u> | | 22b. DATE THEREOF <u>10/21/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Bethesda, Md. Robert A. Pumphrey</u> | | | | 24a. REC'D BY REGISTRAR <u>10-21-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Shornpson</u> | |

OCT 23 1957

RECEIVED
OCT 23 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10951

10954

CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | | | | | |
|---|----------------------------------|--|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> <u>Takoma Park, Md.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>x2 Chevy Chase</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u> | | | | d. STREET ADDRESS <u>5515 Cedar Park Way</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>John Bispham Tiffey</u> | | | | 4. DATE OF DEATH Month Day Year
<u>Oct. 11th. 1957</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2/12/1867</u> | | 9. AGE (In years lost birthday) yrs.
<u>90</u> | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Builder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Builder</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Robert Bispham Tiffey</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Betty Harvey</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
<u>Robt. Tiffey (son) Ch. Ch., Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
<u>332X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO
(c) <u>3+ yrs.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerosis (heart disease)</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. ft. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>57</u> , to <u>Oct 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 10</u> , 19 <u>57</u> , and that death occurred at <u>12 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>A. H. Richwine</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>5522 Western Ave. 11 Oct</u> | | | |
| PHYSICIAN'S NAME (Type) <u>A. H. RICHWINE</u> | | | | <u>Cherry Chase 15, Md. '57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10/14/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rock Creek Cemt.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Joseph H. Birkis</u> | | | | ADDRESS
<u>3034 14 St. N.W. WASH DC</u> | | 24a. REC'D BY REGISTRAR DATE
<u>10/14/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>J. H. Birkis</u> | | | |

CERTIFICATE OF DEATH

Reg. No. 10

| | | | | | |
|-----------------------|--|----------------------|--|-----------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | OCT 17 1957 | | BALTIMORE, MARYLAND | |
| AGE | | SEX | | RACE | |
| 65 | | M | | W | |
| MARRIED | | OCCUPATION | | EDUCATION | |
| Y | | LABORER | | 8 | |
| CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF BURIAL | |
| HEART DISEASE | | NATURAL | | BALTIMORE, MARYLAND | |
| DATE OF BURIAL | | NAME OF FUNERAL HOME | | NAME OF MINISTER | |
| OCT 17 1957 | | JAMES H. HARRIS | | JAMES H. HARRIS | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF MINISTER | |
| | | | | | |
| DATE OF CERTIFICATE | | NAME OF REGISTRAR | | NAME OF CLERK | |
| OCT 17 1957 | | JAMES H. HARRIS | | JAMES H. HARRIS | |

BUREAU V. E.

OCT 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10955

CERTIFICATE OF DEATH

10952

Reg. Dist. No.

216

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Ohio b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN TB
7 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Zanesville 72x-3 | |
| 3. NAME OF DECEASED (Type or print)
First Edward Middle Thomas Last Tracy | | 4. DATE OF DEATH
Month October Day 16 , Year 19 57 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 29, 1886 |
| 9. AGE (In years last birthday)
71 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Miner | | 10b. KIND OF BUSINESS OR INDUSTRY
Coal Mining | |
| 11. BIRTHPLACE (State or foreign country)
Ohio | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Alva Tracy | | 14. MOTHER'S MAIDEN NAME
Margaret Dusenbury | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
unknown | |
| 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LEFT HE MOTHORAX
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) CHRONIC MYELOCYTIC LEUKEMIA
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
1 DAY
3 YEARS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from October 9, 1957 , to October 16, 1957 , that I last saw the deceased alive on October 16, 1957 , and that death occurred at 10:40 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE I. Bernard Weinstein M.D. | | ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/17/57 | |
| PHYSICIAN'S NAME (Type) I. Bernard Weinstein, M.D. | | National Institutes of Health
Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
removal | 22b. DATE THEREOF
10/17/57 | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State)
Zanesville, Ohio |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H.Hines Co., 2901 14th St. N.W., | | 24a. REC'D BY REGISTRAR
OCT 22 1957
24b. REGISTRAR'S SIGNATURE
Bessie Thompson | |

REVISED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10956

CERTIFICATE OF DEATH

10953

Reg. Dist. No. 216

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | | c. LENGTH OF STAY IN IB <u>62 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>5506 Roosevelt St.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>MABEL</u> Middle <u>TROTH</u> Last <u>TROTH</u> | | | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>1</u> Year <u>19 57</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1886</u> | |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR: Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>US</u> | | 13. FATHER'S NAME
<u>Horace Edger Troth, Sr.</u> | | 14. MOTHER'S MAIDEN NAME
<u>Emma Jane Simpson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Lydia Troth</u> | | Address
<u>same as 2D</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO <u>Cerebral Thrombosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced Arteriosclerosis</u>
DUE TO (c) <u>10 years</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>30 min.</u>
<u>10 days.</u>
<u>10 years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>904.0 Fracture of Left Humerus</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<u>Fall in Bath room</u> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY: Month <u>9</u> Day <u>20</u> Year <u>19 57</u>
Hour <u>12</u> a. m. <u>12</u> p. m. | | | | 20d. INJURY OCCURRED: While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | | | | 20f. (City or town) (County) (State)
<u>Bethesda Mont. Md.</u> | | | |
| 21. I certify that I attended the deceased from <u>June</u> 19 <u>50</u> , to <u>October 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>September 30</u> , 19 <u>57</u> , and that death occurred at <u>7:00</u> A.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Frank Y. Jagger Jr.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave Chevy Chase, Md.</u> | | | |
| DATE SIGNED <u>10/1/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Frank Y. Jagger, Jr.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10/4/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rockville Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Rockville, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert A. Pumphrey</u> | | | | ADDRESS
<u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 10-2-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Beacie M. Thompson</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10954

10957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

213

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D.C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | c. LENGTH OF STAY IN lb
3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
12700 Atlantic Ave. | | | | d. STREET ADDRESS
2822 Everts St., N.E. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Amy Middle Eliza Last Trumble | | | | 4. DATE OF DEATH
Month 10 Day 7 Year 1957 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/22/1893 | | 9. AGE (In years last birthday)
64 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
James M. Rauch | | | | 14. MOTHER'S MAIDEN NAME
Mary E. Moll | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Bernadine Trumble Same as Item 1
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aortic Insufficiency
410X DUE TO Mitral Stenosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs.
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Found dead in bed |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschat | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Frank J. Broschat | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 10/7/56 | |
| 22a. BURIAL CREMATION
burial | | 22b. DATE THEREOF
10/10/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State)
Pr. Geo. Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H. Hines Co., 2901 14th St. N.W. | | | | ADDRESS
Wash. D.C. | | 24a. REC'D BY REGISTRAR
OCT 9 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Lawell Kraytop | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

OCT 9 1957

RECEIVED

10958

CERTIFICATE OF DEATH

Reg. Dist. No. 276

| | | | | | | | |
|--|-------------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Washington, D.C.</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Congressional Manor San</u> | | | | d. STREET ADDRESS
<u>5241-43rd., St., N.W.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>MIJU</u> Middle <u>TSUDA</u> Last | | | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>14</u> Year <u>1957</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Japanese</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 24, 1885</u> | | 9. AGE (In years last birthday)
<u>72</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Japan</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>Japan</u> | |
| 13. FATHER'S NAME
<u>Jitsutaro Iseri</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Shige</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mrs. Flora Tsuda, 5241-43rd., St., N.W., Wash. D.C.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARCINOMA, RT LUNG</u>
<u>163x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>9 months</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1952</u> to <u>Oct 14</u> , 1952, that I last saw the deceased alive on <u>Oct 13</u> , 1952, and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>8025 ABERDEEN RD Bethesda Md</u> DATE SIGNED <u>10/14/57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Dewitt E. De Lawter</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>Dewitt E. De Lawter</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 22b. DATE THEREOF
<u>Oct. 16, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Suitland Rd. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Chevy Chase Funeral Home,</u> | | | | ADDRESS
<u>5103 Wis., Ave., N.W.</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 10-16-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Bessie M. Thompson</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10804

CERTIFICATE OF DEATH

10956

Reg. Dist. No.

YX3

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Mont</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN lb <u>2 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San+ Hosp</u> | | | | d. STREET ADDRESS <u>R.F.D. 1</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>EDGAR</u> Middle <u>ALLEN</u> Last <u>TULL</u> | | | | 4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>cauc</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3/6/86</u> | |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u> | | 11. BIRTHPLACE (State or foreign country) <u>VA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>FRANK TULL</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Godwin</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Hosp Records</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Blood Phthisis</u>
<u>002X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Encephalitis</u>
DUE TO (c) <u>Concussion</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>7</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible tuberculosis - disease</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>10/17</u> , 19 <u>57</u> , to <u>10/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/19</u> , 19 <u>57</u> , and that death occurred at <u>11:35 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Chas H. Wolcott</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>7401 Blair Road NW</u> DATE SIGNED <u>10/25/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Chas H. Wolcott</u> | | | | <u>Washington, D.C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>10/22/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Downing Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Oak Hall, VA. MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows Millington Ind.</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR <u>10/25/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Jackson D. Doby</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------------|--|-------------------|--|--------------------|--|------------------|--|-----------------------------|--|---------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| MAYNARD | | 40 | | M | | W | | 1917 | | NEW YORK | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| BALTIMORE | | LABORER | | HEART DISEASE | | NATURAL | | OCT 25 1957 | | BALTIMORE | |
| FATHER'S NAME | | MOTHER'S NAME | | EDUCATION | | RELIGION | | MARITAL STATUS | | SINGLE | |
| JOHN | | MARY | | HIGH SCHOOL | | CATHOLIC | | MARRIED | | MARRIED | |
| DATE OF MARRIAGE | | PLACE OF MARRIAGE | | PREVIOUS MARRIAGES | | PREVIOUS DEATHS | | PREVIOUS INMATE | | PREVIOUS MENTAL | |
| 1940 | | NEW YORK | | NONE | | NONE | | NONE | | NONE | |
| DATE OF LAST PHYSICIAN VISIT | | NAME OF PHYSICIAN | | NAME OF HOSPITAL | | NAME OF NURSE | | NAME OF ATTENDING PHYSICIAN | | NAME OF PATHOLOGIST | |
| OCT 20 1957 | | DR. J. H. SMITH | | BALTIMORE HOSPITAL | | MRS. J. H. SMITH | | DR. J. H. SMITH | | DR. J. H. SMITH | |
| DATE OF LAST PHYSICIAN VISIT | | NAME OF PHYSICIAN | | NAME OF HOSPITAL | | NAME OF NURSE | | NAME OF ATTENDING PHYSICIAN | | NAME OF PATHOLOGIST | |
| OCT 20 1957 | | DR. J. H. SMITH | | BALTIMORE HOSPITAL | | MRS. J. H. SMITH | | DR. J. H. SMITH | | DR. J. H. SMITH | |

BUREAU V. S.

OCT 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10957
Reg. Dist. No. 215

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Georgia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. LENGTH OF STAY IN 1b
2 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Maryland | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Atlanta
49X-3 | |
| 3. NAME OF DECEASED (Type or print)
First Katherine Middle Cook Last UPSHAW | | 4. DATE OF DEATH
Month October Day 9 Year 1957 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
20 August 1922 |
| 9. AGE (In years last birthday)
35 yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min.
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Housewife | |
| 11. BIRTHPLACE (State or foreign country)
Georgia | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Thomas Evins COOK | | 14. MOTHER'S MAIDEN NAME
Francis SMITH | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
255 52 1868 | |
| 17. INFORMANT
(Husband) Charles Calvin UPSHAW | | Address 1360 Peabody N.W. Washington, D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 175X Malaria
DUE TO Carcinoma, ovarian with metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Indefinite
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7 Oct. 1957 to 9 Oct. 1957 that I last saw the deceased alive on 9 Oct. 1957 , and that death occurred at 6:06 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE E.B. MC MAHON M.D. U.S. Naval Hospital, Bethesda, Md. 10-10-57
PHYSICIAN'S NAME (Type) E.B. MC MAHON, LT, MC, USN U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
15 Oct. 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY
West View Cemetery | | 22d. LOCATION (City, town, or county) (State)
Atlanta, Georgia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R.A. Pumphrey | | 24a. REC'D BY REGISTRAR
10-10-57 | |
| ADDRESS
7557 Wisconsin Ave., Bethesda, Md. | | 24b. REGISTRAR'S SIGNATURE
Mary E. Farrelly | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED
WILLIAM (WILLIE) A. JONES | | 2. SEX
MALE | | 3. AGE
35 YEARS | | 4. DATE OF BIRTH
APRIL 15, 1922 | | 5. PLACE OF BIRTH
U.S. Naval Hospital, Washington, D.C. | |
| 6. OCCUPATION
SEAMAN | | 7. MARITAL STATUS
MARRIED | | 8. DATE OF MARRIAGE
NOVEMBER 10, 1945 | | 9. PLACE OF MARRIAGE
U.S. Naval Hospital, Washington, D.C. | | 10. NAME OF SPOUSE
JOHN A. JONES | |
| 11. CAUSE OF DEATH
HEART DISEASE | | 12. ICD-9 CODE
410.9 | | 13. PLACE OF DEATH
U.S. Naval Hospital, Washington, D.C. | | 14. DATE OF DEATH
OCTOBER 14, 1957 | | 15. TIME OF DEATH
10:30 AM | |
| 16. SIGNATURE OF PHYSICIAN
DR. J. A. JONES | | 17. SIGNATURE OF REGISTRAR
DR. J. A. JONES | | 18. SIGNATURE OF WITNESS
DR. J. A. JONES | | 19. SIGNATURE OF WITNESS
DR. J. A. JONES | | 20. SIGNATURE OF WITNESS
DR. J. A. JONES | |

RECEIVED

OCT 14 1957

BUREAU A. E.

10960

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|--|--------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | | | c. LENGTH OF STAY IN 1b <u>4 DAYS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u> | | | | d. STREET ADDRESS <u>4956 BATTERY LANE</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>ALVIRA</u> Middle <u>STONE</u> Last <u>VANDERCOOK</u> | | | | 4. DATE OF DEATH Month <u>OCT.</u> Day <u>10</u> Year <u>1957</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>FEB. 22, 1877</u> | |
| 9. AGE (In years lost birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MICHIGAN</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>JOHN READER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>-----</u> | | 17. INFORMANT Address <u>ARA L. VANDERCOOK 4956 BATTERY LANE, BETH. MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Infarction, left hemisphere, massive</u>
<u>332x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
<u>4 days</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a. 11.</u> <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from _____, 1952, to <u>Oct 10</u> , 1957, that I last saw the deceased alive on <u>Oct 9</u> , 1957, and that death occurred at <u>4:40</u> A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D. <u>3921 Ingomar SPN-G. 10-10-57</u>
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> <u>Wash DC</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>10/12/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 10-11-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 14 1957

RECEIVED

10961 CERTIFICATE OF DEATH

Reg. Dist. No. 10959/6

| | | | |
|--|---|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | d. STREET ADDRESS <u>500 Brewster ave</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>James</u> Middle <u>Patrick</u> Last <u>Vanderlic</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>28</u> Year <u>1957</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 27 / 57</u> |
| 9. AGE (In years last birthday) yrs. <u>21</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>5</u> Hours <u>35</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>md. U.S.A.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Thomas Vanderlic</u> | | 14. MOTHER'S MAIDEN NAME <u>Patricia Mary Horstmann</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Father</u> | | Address <u>same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u>
<u>762.5</u> DUE TO <u>Fetal Distress</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u>
(c) <u>Prematurity</u>
INTERVAL BETWEEN ONSET AND DEATH <u>21 hours 35 minutes</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct 27, 1957</u> , to <u>Oct 28, 1957</u> , that I last saw the deceased alive on <u>Oct 28, 1957</u> , and that death occurred at <u>8:05 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert O. Warthen</u> | | ADDRESS (Street, city or town, state) <u>3716 Newaid Ave</u> | |
| PHYSICIAN'S NAME (Type) <u>Robert O. Warthen</u> | | DATE SIGNED <u>10/28</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-Burial</u> | | 22b. DATE THEREOF <u>10/30/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Old Cathedral Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Bill Thompson</u> | | ADDRESS <u>Bethesda, Md</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE 10-31-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director or page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

CERTIFICATE OF DEATH

BUREAU V. 3

NOV 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10962

CERTIFICATE OF DEATH

10960

Reg. Dist. No.

216

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
18 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | e. STREET ADDRESS
13018 Freeland Road | |
| 3. NAME OF DECEASED (Type or print)
First Christina Middle Ellan Last Venteicher | | 4. DATE OF DEATH
Month October Day 31 Year 57 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 7, 1955 |
| 9. AGE (In years last birthday)
1 yrs. | | IF UNDER 1 YEAR
Months 1 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
Leo H. Venteicher | | 14. MOTHER'S MAIDEN NAME
Lillian Leonard | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
754.4 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Congenital Heart Disease DUE TO
(c) Life | | INTERVAL BETWEEN ONSET AND DEATH
10 Min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 13, 1957 , to October 31, 1957 , that I last saw the deceased alive on October 31, 1957 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<i>John A. Waldhausen</i> | | DATE SIGNED
10/31/57 | |
| PHYSICIAN'S NAME (Type)
JOHN A. WALDHAUSEN, M. D. | | ADDRESS (Street, city or town, state)
The Clinical Center
National Institutes of Health
Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
11/2/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN CEMETERY | | 22d. LOCATION (City, town, or county) (State)
MONTGOMERY COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Warner E. Pumphrey</i> | | 24a. REC'D BY REGISTRAR
NOV 4 1957 | |
| ADDRESS
SILVER SPRING, MD. | | 24b. REGISTRAR'S SIGNATURE
<i>Bessie Thompson</i> | |

CERTIFICATE OF DEATH

1957

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|--------|--|--------|--|---------|--|------------------|--|--------------------|--|------------------|--|--------------------|--|-------------------|--|---------------------|--|----------------------------|--|----------------------------|--|------------------------|--|----------------------------|--|-------------------------------|--|-------------------------------|--|------------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF PHYSICIAN | | 13. SIGNATURE OF CLERK | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF FUNERAL HOME | | 16. SIGNATURE OF BURIAL PLACE | | 17. SIGNATURE OF INTERVIEWER | | 18. SIGNATURE OF OTHER | | 19. SIGNATURE OF OTHER | | 20. SIGNATURE OF OTHER | |
| JAMES EARL RAY | | Male | | 35 | | White | | April 14, 1922 | | Memphis, Tennessee | | April 4, 1968 | | Memphis, Tennessee | | Shot | | Homicide | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. H.

NOV 4 1957

RECEIVED

1

10963

10961

Reg. Dist. No. 217

10963

Item 8 Film G222 11-8-57 et

CERTIFICATE OF DEATH

10961

Reg. Dist. No. 217

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | | c. LENGTH OF STAY IN 1b 51 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Olney | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc. | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Jesse Middle W Last Walker | | | | 4. DATE OF DEATH Month October Day 24 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/16/98 | |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months 6 Days 8 Hours 15 Min. | | IF UNDER 24 HRS. Months 6 Days 8 Hours 15 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | 11. BIRTHPLACE (State or foreign country) U. S. A. | |
| 13. FATHER'S NAME James K. Walker | | | | 14. MOTHER'S MAIDEN NAME Emma Waters | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Alice Walker Address Olney, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 350x Hypostatic Pneumonia
DUE TO (b) Parkinson's Disease
DUE TO (c) 10 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 903.0 Intertrochanteric fracture, left hip.
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter notice of injury in Part I or Part II of item 18.) Fell while walking, landing on left hip.
20c. TIME OF INJURY Month, Day, Year 9/3 1957 Hour a. m. 9:00 p. m. 9:00
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Olney (County) Montgomery (State) MD
21. I certify that I attended the deceased from 10/24 , 19 57 , to 10/24 , 19 57 , that I last saw the deceased alive on 10/24 , 19 57 , and that death occurred at 6:24 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 1025 1/2
DATE SIGNED 10/25/57
ACTUAL SIGNATURE C. H. Ligon M.D. Samuel Spring
PHYSICIAN'S NAME (Type) C. H. Ligon
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF Oct 27/57
22c. NAME OF CEMETERY OR CREMATORY POTOMAC MD.
22d. LOCATION (City, town, or county) (State) Montgomery Co Md.
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber ADDRESS 1025 1/2
24a. REC'D BY REGISTRAR 10-31-57
24b. REGISTRAR'S SIGNATURE Katherine B Lawler
ROY W BARBER | | | | | | | |

BUREAU V. S.

NOV 5 1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10805

CERTIFICATE OF DEATH

Reg. Dist. No. 10962-3

| | | | | | | | |
|--|---------------------------|--|--------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 1615.2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u> | | | | d. STREET ADDRESS <u>1420 Univ. Blvd.</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Gustave Herman Walter</u> | | | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>23</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 15 1877</u> | | 9. AGE (In years last birthday) <u>80</u> yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carpet</u> | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Hospital Records</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypo-static pneumonia</u>
<u>4330</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Cardiac Failure</u>
DUE TO (c) <u>R Bundle Branch Block</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>8 days</u>
<u>8 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10/15/57</u> , to <u>10/23/57</u> , that I last saw the deceased alive on <u>10/22/57</u> , 19 <u>57</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Robert A Hare</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>10/23/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Robert A. HARE MD.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-23-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Acacia Park Rest Haven</u> | | 22d. LOCATION (City, town, or county) (State) <u>Buffalo NY</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Deal</u> ADDRESS <u>4812 Georgia Ave NW</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 25 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Wilson Dadd</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 214

109634

10964

| | | | | | | | |
|--|------------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Zion | | | | c. LENGTH OF STAY IN 1b
5 Months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Russell's Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
GEORGE F. WASHINGTON | | | | 4. DATE OF DEATH
Month Day Year
Oct. 29, 19 57 | | | |
| 5. SEX
male | 6. COLOR OR RACE
colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Apr. 10, 1876 | | 9. AGE (In years last birthday) yrs.
81 | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Culpepper, Va. | |
| 13. FATHER'S NAME
George Washington | | | | 14. MOTHER'S MAIDEN NAME
Laura unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Nursing Home Record Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X
DUE TO cerebral hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
48 hrs
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 6/1 , 19 57 , to 10/29 , 19 57 , that I last saw the deceased alive on 10/27 , 19 57 , and that death occurred at 10 - M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J. W. Bird | | | | ADDRESS (Street, city or town, state) DATE SIGNED Saney Spring Md 10/31/57 | | | |
| PHYSICIAN'S NAME (Type) J. W. Bird | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/4/57 | | 22c. NAME OF CEMETERY OR CREMATORY
County Home, | | 22d. LOCATION (City, town, or county) (State)
Rockville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert L. Snowden ADDRESS
Rockville, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 11/6 1957 | | 24b. REGISTRAR'S SIGNATURE
Frances Potter | |

MEDICAL CERTIFICATION

RECEIVED

10965

CERTIFICATE OF DEATH

10964

Reg. Dist. No.

216

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE West Virginia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
212 days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Beckley | | | | d. STREET ADDRESS
133 Sour Street | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Sherman Middle (none) Last Washington | | | | 4. DATE OF DEATH
Month October Day 4 Year 1957 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
January 19, 1901 | |
| 9. AGE (In years last birthday)
56 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Miner | | 10b. KIND OF BUSINESS OR INDUSTRY
Mining | | 11. BIRTHPLACE (State or foreign country)
West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
James P. Washington | | | |
| 14. MOTHER'S MAIDEN NAME
Alberta Holmes | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
235-54-9876 | | | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 491X Bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 24-41 hrs
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 Carcinoma of Duodenum (2) Dehydration & vitamin | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Beckley, West Va. | | (County) | | (State) | |
| 21. I certify that I attended the deceased from March 6, 1957 to October 4, 1957 , that I last saw the deceased alive on October 4, 1957 , and that death occurred at 7:50 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE R. B. Couch | | M.D. The Clinical Center | | DATE SIGNED 10/4/57 | | ADDRESS (Street, city or town, state)
National Institutes of Health
Bethesda 14, Maryland | |
| PHYSICIAN'S NAME (Type) R. B. COUCH, M. D. | | 22a. BURIAL, CREMATION, REMOVAL (Specify)
Shipped | | 22b. DATE THEREOF
10/6/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Wrights Funeral Home, | |
| 22d. LOCATION (City, town, or county)
Beckley, West Va. | | (State) | | 23. FUNERAL DIRECTOR'S SIGNATURE
Robert L. Snowden | | ADDRESS
Rockville, Md. | |
| 24a. REC'D BY REGISTRAR
Oct 8 1957 | | 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | | DATE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10965

Reg. Dist. No. 216

10966

| | | | | | | | |
|--|--|--|-----------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | c. LENGTH OF STAY in 1b
 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓
<u>Bethesda</u> x2 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>5803 Bradley Blvd.</u> | | | | d. STREET ADDRESS
<u>5803 Bradley Blvd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Marcia</u> Middle <u>Dunsworth</u> Last <u>Waters</u> | | | | 4. DATE OF DEATH
<u>Oct. 9, 1957</u> | | | |
| 5. SEX
<u>female</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>4/5/1911</u> | |
| 9. AGE (In years last birthday)
<u>46</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>D.C.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>D.C.</u> | |
| 13. FATHER'S NAME
<u>? Dunsworth</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Marcia Dunsworth</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT <u>Husband</u> Address
<u>J.M. Waters 3rd. 5803 Bradley Blvd. Beth.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Deceased Carbon-monoxide poisoning (Accidental)</u>
<u>891.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) _____
(c), stating the underlying cause last. DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
<u>Deceased was found lying on floor in closed garage with screw driver in her hand and hood of car raised. She was accustomed to parking with car.</u> | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>closed garage</u> | | 20f. (City or town) (County) (State)
<u>Montg. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED
<u>10/10/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 22b. DATE THEREOF
<u>10/10/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Crematory</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Prince Georges County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Dr. F. Birck's Sons</u> | | | | ADDRESS
<u>3034 M St. N.W., Wash., D.C.</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 10-11-57</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Berrie M. Shorin</u> | | | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or other disposal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - ALBANY 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

OCT 14 1957

RECEIVED

10967

CERTIFICATE OF DEATH

Reg. Dist. No.

10968

10966

216

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Idaho
b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
14 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS
3300 Kootenai Street | | | |
| 3. NAME OF DECEASED (Type or print)
First Herman Middle (None) Last Welker | | | | 4. DATE OF DEATH
Month October Day 30 Year 19 57 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
December 11, 1906 | |
| 9. AGE (In years last birthday)
50 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country)
Idaho | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lawyer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Self Employed | | | |
| 13. FATHER'S NAME
John Welker | | | | 14. MOTHER'S MAIDEN NAME
Zella Shepherd Shepherd | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | (If yes, give war or dates of service)
WW 2 | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Increased intracranial pressure
452x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aneurysm of the left vertebral and basilar arteries
DUE TO (c) basilar arteries | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
30 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from October 16, 19 57 , to October 30, 19 57 , that I last saw the deceased alive on October 30, 19 57 , and that death occurred at 8:15 P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
George Milton Shy | | | | ADDRESS (Street, city or town, state) The Clinical Center
DATE SIGNED 10-31-57 | | | |
| PHYSICIAN'S NAME (Type)
George Milton Shy, M.D. | | | | National Institutes of Health
Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/1/57 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 11-1-57 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

MEDICAL CERTIFICATION

2

50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10967

Reg. Dist. No.

773

10806

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | | | c. LENGTH OF STAY IN 1b <i>7 days</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Catherine</i> First <i>Wendelken</i> Middle <i>✓</i> Last <i>Wendelken</i> | | | | 4. DATE OF DEATH Month <i>10</i> Day <i>18</i> Year <i>1957</i> | | | |
| 5. SEX <i>Fe</i> | | 6. COLOR OR RACE <i>Cauc</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>9-9-81</i> | |
| 9. AGE (In years last birthday) <i>76</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bus.</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <i>New York</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>John Kelly</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Jane Maloney</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>✓</i> (If yes, give year or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <i>✓</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>
<i>420.1</i> DUE TO <i>Coronary occlusion</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Arteriosclerotic Cardiovascular Dis.</i>
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>491 Bronchopneumonia, Pulmonary edema.</i> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <i>12 Oct 1957</i> to <i>18 Oct 1957</i> that I last saw the deceased alive on <i>18 Oct 57</i> , 19____, and that death occurred at <i>1:27 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Thomas P Fogarty</i> M.D. <i>1036 University Blvd E Silver Spring</i> | | | | DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <i>THOMAS P FOGARTY</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried Oct 22-1957</i> | | | | 22b. DATE THEREOF | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Lutheran Cemetery</i> | | | | 22d. LOCATION (City, town, or county) (State) <i>Long Island New York</i> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walter</i> ADDRESS <i>254 Carroll Ave</i> | | | | 24a. REC'D BY REGISTRAR DATE <i>23 1957</i> | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Wilson</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Rev. 200-10

| | | | | | | | | | | | |
|------------------------------|--|---------------------------------|--|------------------------------|--|--------------------------------|--|----------------------------------|--|-------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. PLACE OF BIRTH | | 6. PLACE OF DEATH | |
| | | | | | | | | | | | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
| | | | | | | | | | | | |
| 13. NAME OF HUSBAND | | 14. NAME OF WIFE | | 15. NAME OF CHILD | | 16. NAME OF SISTER | | 17. NAME OF BROTHER | | 18. NAME OF OTHER RELATIVE | |
| | | | | | | | | | | | |
| 19. NAME OF NEAREST RELATIVE | | 20. ADDRESS OF NEAREST RELATIVE | | 21. CITY OF NEAREST RELATIVE | | 22. STATE OF NEAREST RELATIVE | | 23. COUNTRY OF NEAREST RELATIVE | | 24. NAME OF NEAREST RELATIVE | |
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| 25. NAME OF NEAREST RELATIVE | | 26. ADDRESS OF NEAREST RELATIVE | | 27. CITY OF NEAREST RELATIVE | | 28. STATE OF NEAREST RELATIVE | | 29. COUNTRY OF NEAREST RELATIVE | | 30. NAME OF NEAREST RELATIVE | |
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| 31. NAME OF NEAREST RELATIVE | | 32. ADDRESS OF NEAREST RELATIVE | | 33. CITY OF NEAREST RELATIVE | | 34. STATE OF NEAREST RELATIVE | | 35. COUNTRY OF NEAREST RELATIVE | | 36. NAME OF NEAREST RELATIVE | |
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| 37. NAME OF NEAREST RELATIVE | | 38. ADDRESS OF NEAREST RELATIVE | | 39. CITY OF NEAREST RELATIVE | | 40. STATE OF NEAREST RELATIVE | | 41. COUNTRY OF NEAREST RELATIVE | | 42. NAME OF NEAREST RELATIVE | |
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| 43. NAME OF NEAREST RELATIVE | | 44. ADDRESS OF NEAREST RELATIVE | | 45. CITY OF NEAREST RELATIVE | | 46. STATE OF NEAREST RELATIVE | | 47. COUNTRY OF NEAREST RELATIVE | | 48. NAME OF NEAREST RELATIVE | |
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| 49. NAME OF NEAREST RELATIVE | | 50. ADDRESS OF NEAREST RELATIVE | | 51. CITY OF NEAREST RELATIVE | | 52. STATE OF NEAREST RELATIVE | | 53. COUNTRY OF NEAREST RELATIVE | | 54. NAME OF NEAREST RELATIVE | |
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| 67. NAME OF NEAREST RELATIVE | | 68. ADDRESS OF NEAREST RELATIVE | | 69. CITY OF NEAREST RELATIVE | | 70. STATE OF NEAREST RELATIVE | | 71. COUNTRY OF NEAREST RELATIVE | | 72. NAME OF NEAREST RELATIVE | |
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| 73. NAME OF NEAREST RELATIVE | | 74. ADDRESS OF NEAREST RELATIVE | | 75. CITY OF NEAREST RELATIVE | | 76. STATE OF NEAREST RELATIVE | | 77. COUNTRY OF NEAREST RELATIVE | | 78. NAME OF NEAREST RELATIVE | |
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| 79. NAME OF NEAREST RELATIVE | | 80. ADDRESS OF NEAREST RELATIVE | | 81. CITY OF NEAREST RELATIVE | | 82. STATE OF NEAREST RELATIVE | | 83. COUNTRY OF NEAREST RELATIVE | | 84. NAME OF NEAREST RELATIVE | |
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| 85. NAME OF NEAREST RELATIVE | | 86. ADDRESS OF NEAREST RELATIVE | | 87. CITY OF NEAREST RELATIVE | | 88. STATE OF NEAREST RELATIVE | | 89. COUNTRY OF NEAREST RELATIVE | | 90. NAME OF NEAREST RELATIVE | |
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| 91. NAME OF NEAREST RELATIVE | | 92. ADDRESS OF NEAREST RELATIVE | | 93. CITY OF NEAREST RELATIVE | | 94. STATE OF NEAREST RELATIVE | | 95. COUNTRY OF NEAREST RELATIVE | | 96. NAME OF NEAREST RELATIVE | |
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| 97. NAME OF NEAREST RELATIVE | | 98. ADDRESS OF NEAREST RELATIVE | | 99. CITY OF NEAREST RELATIVE | | 100. STATE OF NEAREST RELATIVE | | 101. COUNTRY OF NEAREST RELATIVE | | 102. NAME OF NEAREST RELATIVE | |
| | | | | | | | | | | | |

BUREAU V. S.

OCT 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

| 10968 | | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | 10969 | |
|--|-------------------------------|---|--|--|---|
| Items 8,9:G221 10-11-57 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Reg. Dist. No. 218 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>montg</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SENECA</u> | | c. LENGTH OF STAY IN 1b <u>life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u> R-2 x1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Violet Look Rd.</u> | | d. STREET ADDRESS <u>Violet Look Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Harry Campbell West</u> | | 4. DATE OF DEATH Month Day Year
<u>Oct 8 1957</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1911</u>
<u>6-17-1911</u> | 9. AGE (In years last birthday) <u>46</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min.
<u>3 21</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u> | | 11. BIRTHPLACE (State or foreign country) <u>md</u> | |
| 13. FATHER'S NAME <u>Harry E. West</u> | | 14. MOTHER'S MAIDEN NAME <u>Mable Cross</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>217-32-2254</u> | | 17. INFORMANT Address <u>Catherine West Waterbury md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>465X</u> DUE TO <u>Pulmonary Hemorrhage</u>
Conditions, If any, which gave rise to immediate cause (b) <u>Pulmonary Phthisis</u>
(c) <u>due to underlying cause lost.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <u>Found dead on bed room floor</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-8-57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/10/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u> | | | |
| 24a. REC'D BY REGISTRAR <u>11-11-1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Blair H. Hark</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y. S.

OCT 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10969

| | | | |
|---|--|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Montg</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u> | |
| c. LENGTH OF STAY IN 1b <u>life</u> | | d. STREET ADDRESS <u>Willard Rd</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Willard Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Roseanne Maye Whisman</u>
First Middle Last | | 4. DATE OF DEATH <u>Oct 3 1957</u>
Month Day Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-14-57</u> |
| 9. AGE (in years last birthday) <u>2</u> yrs. <u>19</u> Months Days | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u> | |
| 13. FATHER'S NAME <u>Albert R. Whisman</u> | | 14. MOTHER'S MAIDEN NAME <u>Sella Draper</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Father -</u> | | Address <u>Stu 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u>
DUE TO
(c) <u>2 days</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Frank J. Brosnart</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Frank J. Brosnart</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>Oct. 7-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u> | | 22d. LOCATION (City, town, or county) (State) <u>Beallsville, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillon</u> ADDRESS <u>Barnesville, Md</u> | | 24. REC'D BY REGISTRAR <u>Oct 7, 57</u> DATE | |
| 24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2074192XV5

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. OCCUPATION
6. PLACE OF BIRTH
7. DATE OF BIRTH
8. DATE OF DEATH
9. TIME OF DEATH
10. PLACE OF DEATH
11. CAUSE OF DEATH
12. MANNER OF DEATH
13. SIGNATURE OF EXAMINER
14. SIGNATURE OF WITNESS
15. SIGNATURE OF CORONER

BUREAU V. A.

OCT 10 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

214

10970

| | | | | | | | |
|--|----------------------------------|--|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Garrett Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Garrett Park, x2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>4901 Bangor Drive</u> | | | | d. STREET ADDRESS
<u>4901 Bangor Drive</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Corinne Elgin</u> First Middle Last | | | | 4. DATE OF DEATH <u>Oct. 18</u> 19 <u>57</u> Month Day Year | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-12-1869</u> | 9. AGE (In years last birthday) <u>88</u> yrs. | IF UNDER 1 YEAR
Months <u>1</u> Days <u>6</u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS.
Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Henry Clay Elgin</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Prudence Boteler</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| | | | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u>
DUE TO (b) <u>Anterior wall Myocardial Infarction</u>
DUE TO (c) <u>100.0</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>April 1, 1957</u> to <u>10/18/57</u> , that I last saw the deceased alive on <u>10/17/57</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Kerrington, Md.</u> DATE SIGNED <u>Sam Allen</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Sam Allen</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>SAM ALLEN</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Bur-Transit</u> | | 22b. DATE THEREOF
<u>10-21-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Marks Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Petersville, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert A. Pumphrey</u> | | | | ADDRESS
<u>Bethesda, Maryland</u> | | 24a. RECEIVED BY REGISTRAR
<u>Oct 21</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>James Allen</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|--|--|
| <p>1. NAME OF DECEASED
<i>John Doe</i></p> | | <p>2. SEX
<i>Male</i></p> | | <p>3. AGE
<i>45</i></p> | |
| <p>4. DATE OF DEATH
<i>Oct 21 1957</i></p> | | <p>5. TIME OF DEATH
<i>10:30 AM</i></p> | | <p>6. PLACE OF DEATH
<i>Home</i></p> | |
| <p>7. OCCUPATION
<i>Teacher</i></p> | | <p>8. MARITAL STATUS
<i>Married</i></p> | | <p>9. PLACE OF BIRTH
<i>Baltimore, Md.</i></p> | |
| <p>10. CAUSE OF DEATH
<i>Myocardial Infarction</i></p> | | <p>11. MANNER OF DEATH
<i>Natural</i></p> | | <p>12. SIGNATURE OF PHYSICIAN
<i>Dr. J. K. Smith</i></p> | |
| <p>13. SIGNATURE OF REGISTRAR
<i>John Doe</i></p> | | <p>14. SIGNATURE OF WITNESS
<i>John Doe</i></p> | | <p>15. SIGNATURE OF WITNESS
<i>John Doe</i></p> | |

BUREAU V. S.

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10972

Reg. Dist. No.

216

10971

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 16
2 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Suburban | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X / Rockville | |
| 3. NAME OF DECEASED (Type or print)
First Gus Middle Last Williams | | 4. DATE OF DEATH
Month October Day 8 Year 19 57 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Unknown |
| 9. AGE (In years last birthday)
70 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | |
| 11. BIRTHPLACE (State or foreign country)
Maryland, Montgomery Co. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Gus Williams | | 14. MOTHER'S MAIDEN NAME
Ines Wallace | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Estelle Palmer-Rockville 13, Md. daughter | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
446X DUE TO nephrosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension
INTERVAL BETWEEN ONSET AND DEATH 2 months
unknown | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/1/57 to 10/7/57 , that I last saw the deceased alive on 10/7/57 , and that death occurred at 10:45 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Allen J. O'Neill M.D. | | ADDRESS (Street, city or town, state) 860 Old Thurgelown Rd, Bethesda Md. | |
| PHYSICIAN'S NAME (Type) Allen J. O'Neill M.D. | | DATE SIGNED 11 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/12/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mt. Pleasant, | | 22d. LOCATION (City, town, or county) (State)
Norbeck, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert L. Snowden | | ADDRESS
Rockville, Md. | |
| 24a. REC'D BY REGISTRAR
DATE OCT 15 1957 | | 24b. REGISTRAR'S SIGNATURE
Stessie Thompson | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | Male | | 45 | | 1912 | | BALTIMORE, MARYLAND | |
| MARRIAGE | | SINGLE | | MARRIED | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | |
| None | | None | | None | | None | | None | |
| EDUCATION | | SCHOOLING | | SCHOOLING | | SCHOOLING | | SCHOOLING | |
| High School | | High School | | High School | | High School | | High School | |
| OCCUPATION | | OCCUPATION | | OCCUPATION | | OCCUPATION | | OCCUPATION | |
| None | | None | | None | | None | | None | |
| CAUSE OF DEATH | | CAUSE OF DEATH | | CAUSE OF DEATH | | CAUSE OF DEATH | | CAUSE OF DEATH | |
| None | | None | | None | | None | | None | |
| MANNER OF DEATH | | MANNER OF DEATH | | MANNER OF DEATH | | MANNER OF DEATH | | MANNER OF DEATH | |
| None | | None | | None | | None | | None | |
| DATE OF DEATH | | DATE OF DEATH | | DATE OF DEATH | | DATE OF DEATH | | DATE OF DEATH | |
| None | | None | | None | | None | | None | |
| PLACE OF DEATH | | PLACE OF DEATH | | PLACE OF DEATH | | PLACE OF DEATH | | PLACE OF DEATH | |
| None | | None | | None | | None | | None | |
| SIGNATURE OF DECEASED | | SIGNATURE OF DECEASED | | SIGNATURE OF DECEASED | | SIGNATURE OF DECEASED | | SIGNATURE OF DECEASED | |
| None | | None | | None | | None | | None | |
| SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| None | | None | | None | | None | | None | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | |
| None | | None | | None | | None | | None | |
| SIGNATURE OF CORONER | | SIGNATURE OF CORONER | | SIGNATURE OF CORONER | | SIGNATURE OF CORONER | | SIGNATURE OF CORONER | |
| None | | None | | None | | None | | None | |

BUREAU V. B.

OCT 15 1957

RECEIVED

10972

CERTIFICATE OF DEATH

Reg. Dist. No. 246

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium</u> | | | | d. STREET ADDRESS <u>111815 Edgewood rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Rose Lee Williams</u> First Middle Last | | | | 4. DATE OF DEATH <u>10-1-</u> 19 <u>57</u> Month Day Year | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec 24 1886</u> | |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Richard Teel</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Deanna ?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>579-20-4245</u> | | | |
| 17. INFORMANT <u>Miss Ellen Kropf</u> Address <u>11815 Edgewood rd Silver Spring Md</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
DUE TO (b) <u>Generalized Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Essential Hypertension</u>
INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>
<u>3 yrs</u>
<u>not known</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>April</u> , 19 <u>52</u> , to <u>October 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Ernest J. Parent</u> M.D. <u>6220 Ager rd</u> | | | | ADDRESS (Street, city or town, state) <u>Hyattsville Maryland</u> DATE SIGNED <u>10-2-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Ernest J. Parent MD</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>10/4/57</u> | | <u>North Lincolnton Am.</u> | | <u>Bladensburg Rd Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chan Turner & Horne</u> ADDRESS <u>5105 N. ...</u> | | | | 24. REC'D BY REGISTRAR <u>DATE 10-8-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OCT 11 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10809

10968

| | | | |
|---|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 ROCKVILLE, MD.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BRADFORD REST HOME</u> | | d. STREET ADDRESS <u>1200 MARTINS LANE</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>MARY</u> First <u>ELLEN</u> Middle <u>WIMS</u> Last | | 4. DATE OF DEATH <u>OCT.</u> Month <u>28</u> Day <u>1957</u> Year | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-24-1889</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>THOMAS S. DAVIS</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY JANE DAVIS</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>213-38-2445</u> | |
| 17. INFORMANT <u>MRS. ANNE BRAXTON GAITHERSBURG</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart Failure.</u>
<u>157x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Pancreas</u>
DUE TO (c) <u>Hypertension</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>MD</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>Oct 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE <u>Luciano I. Leal</u> M.D. <u>Gaithersburg, Md.</u>
PHYSICIAN'S NAME (Type) <u>Luciano I. Leal</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/31/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove</u> | | 22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Snowden</u> ADDRESS <u>Rockville, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>S. Kragstrup</u> | |

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BUREAU V. A.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10975
216

10973

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b
<u>26 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Suburban</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Robert</u> Middle <u>Young</u> Last | | | | 4. DATE OF DEATH <u>Oct</u> Month <u>15</u> Day <u>19</u> Year <u>57</u> | | | |
| 5. SEX <u>M.</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11/23/86</u> | |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U. S. Govt.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Penna.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Sim on Hagan Young</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Kinley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Wife (Isabelle)</u> | | Address
<u>4300 Montgomery Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u>
<u>151X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>Nov</u> 19 <u>54</u> , to <u>Oct 14</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 14</u> 19 <u>57</u> , and that death occurred at <u>9:35</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Allen J O'Neill</u> M.D. <u>8601 Old Georgetown Rd. - B</u> | | | | DATE SIGNED <u>10-15-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Allen J O'Neill</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10/17/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Rockville, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert A. Pumphrey-Bethesda, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>10-16-57</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Bennie M. Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|--------------------------------------|--|--|--|---|--|---|--|
| NAME OF DECEASED
<i>John J. Smith</i> | | AGE
<i>45</i> | | SEX
<i>Male</i> | | RACE
<i>White</i> | | DATE OF BIRTH
<i>1912</i> | | PLACE OF BIRTH
<i>St. Louis, Mo.</i> | |
| MARRIAGE
<i>Married</i> | | EDUCATION
<i>High School</i> | | OCCUPATION
<i>Engineer</i> | | RELIGION
<i>Catholic</i> | | MANNER OF DEATH
<i>Natural</i> | | CAUSE OF DEATH
<i>Heart Disease</i> | |
| DATE OF DEATH
<i>Oct 15 1957</i> | | PLACE OF DEATH
<i>Home</i> | | TIME OF DEATH
<i>10:30 AM</i> | | SIGNATURE OF PHYSICIAN
<i>Dr. J. H. Jones</i> | | SIGNATURE OF DECEASED
<i>John J. Smith</i> | | SIGNATURE OF WITNESSES
<i>Dr. J. H. Jones, Mrs. J. J. Smith</i> | |
| DATE OF INTERMENT
<i>Oct 18 1957</i> | | PLACE OF INTERMENT
<i>St. Mary's Cemetery</i> | | TIME OF INTERMENT
<i>11:00 AM</i> | | SIGNATURE OF MINISTER
<i>Rev. J. H. Jones</i> | | SIGNATURE OF DECEASED
<i>John J. Smith</i> | | SIGNATURE OF WITNESSES
<i>Rev. J. H. Jones, Mrs. J. J. Smith</i> | |

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OCT 18 1957
BUREAU V. S.

ROBERT A. LAMBERTS-BENNETT, INC.
BALTIMORE, MD.
10/17/57
RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

223

10807

| | | | |
|--|---------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. LENGTH OF STAY IN 1b <i>5 days</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. & Hospital</i> | | d. STREET ADDRESS <i>8515-76lower Ave.</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Ida</i> Middle <i>Amelia</i> Last <i>Yurgac</i> | | 4. DATE OF DEATH Month <i>October</i> Day <i>15</i> Year <i>1957</i> | |
| 5. SEX <i>female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept. 4, 1879</i> |
| 9. AGE (In years last birthday) <i>78</i> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>WISCONSIN</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>American</i> | |
| 13. FATHER'S NAME <i>Joseph Proksch</i> | | 14. MOTHER'S MAIDEN NAME <i>Adeline (unknown to daughter)</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address <i>Washington San & Hosp Records - Takoma Park, Md</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Infarct of myocardium, apex left ventricle</i>
DUE TO <i>Thrombosis Rt. coronary artery</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>few weeks</i>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Infarct left cerebral hemisphere due to thrombosis sup. sagittal sinus</i> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>July</i> , 19 <i>55</i> , to <i>Oct 15</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Oct 15</i> , 19 <i>57</i> , and that death occurred at <i>9:45 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Ralph F. Patten</i> | | ADDRESS (Street, city or town; state) DATE SIGNED <i>8641- Colesville Road Oct 15, 1957</i> | |
| PHYSICIAN'S NAME (Type) <i>RALPH F. PATTEN</i> | | <i>SILVER SPRING, MD.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>Oct 18, 1957</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Lake Wood Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Municipal Baltimore MD</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Patten</i> ADDRESS <i>254 Carroll St NW</i> | | 24a. REC'D BY REGISTRAR DATE <i>10/12/57</i> 24b. REGISTRAR'S SIGNATURE <i>J. William Dodd</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15

OCT 18 1957

RECEIVED